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An era is fast approaching, when no writer will be read and appreciated by the great majority, save and except those who can effect that for bales of manuscript, that the hydrostatic screw performs for bales of Cotton by condensing that matter into a period that before occupied a page.—COLTON.

ORIGINAL COMMUNICATIONS.

FOR A CRUSADE AGAINST DEAFNESS.*

BY M. M. STAPLER, M.D.,

Macon, Ga.

The great number of defective ears give rise to the suspicion that it is not generally known that in these cases deafness could perhaps have been prevented. The ear is a patient, long suffering member. It does not complain for small cause, and in the early stages of affliction is one of the easiest organs of the body to restore.

Pain in this locality is often prophetic of future deafness, and when pain occurs it is the part of wisdom to seek at once the cause and remove it, or your patient will have defective ears before half of life's allolted span is spent.

An abnormal condition of the ear is usually attended with an abnormal condition of the nose and throat. Treatment of the ears may relieve the pain, but the cause remains, and like a smouldering fire is slowly and surely progressing to a time when there will be more pain or beginning deafness. The conditions could perhaps have been relieved before this time had the serious consequences been suspected and treatment promptly and properly applied. Now it may have assumed a more formidable aspect and there would enter a doubt of the possibility of giving entire relief. As to the other side of the case, the doctor has no doubt that his patient will grow gradually worse if his patient does not accept treatment.

He who relies on nature to establish a normal condition after there is "ringing in the head," an abscess of the middle ear, or beginning deafness, does so because of lack of information on the subject, and is apt to regret it. Doctors who do not warn their patients

* Read before the Macon Medical Society, October 15, 1901.

of the serious nature of the disease are not the guardian angels they should be. It is well known to the profession that a little treatment soon masques these afflictions, by allaying pain, and the patient considers it a small matter quickly cured. Some cases, due to neuralgia or some other reflex cause, may never return; they are the exceptions. The ones not cured may never again have an acute condition giving rise to pain; the only evidence we have that the disease remains is the large number of defective ears. It would be a revelation to most of us to know how many of our acquaintances are partialiy deaf. We doctors, to whom these deaf people applied for treatment of earache, perhaps in their childhood, prescribed rightly some warm vaseline or laudanum water. To that prescriptian should have been added a word about the serious after-effects and some strong advice relative to a radical cure.

Many a man wonders why it is he has become deaf without a warning. It is very probable that pain warned him when a child and his mother stopped the warning by putting sweet oil in his ear. If she called a physician, and he knowing the danger, failed to give the necessary treatment or to tell her of the almost certain evil consequences of neglect, he has incurred a serious responsibility.

As a matter of dollars and cents, it would be very much better for the individual to have proper treatment for an acute condition than to defer until forced to seek relief of a chronic disease.

There is a reasonable hope of preventing deafness if every general practitioner will relieve the acute conditions and then strenuously advise that further treatment be given, by himself, if he is prepared for such work; if not, by some man whom he believes is competent. It would not be long before statistics would show a decline in the number of deaf, as it has shown in the blind since the general adoption of Creed's method.

Parents should be assured when children suffer from their ears that relief of pain is not banishment of the impending deafness. The latter is the sequel of disease, and I do not believe it an exaggeration to say, that a well equipped physician can cure ninety per cent. of all acute cases and a like number of catarrhal ones with a discharge, such as we not only failed formerly to relieve but advised that they be not stopped, lest more serious lesions result. All of that advice is a thing of the past, however, and now with new remedies and methods the treatment of the ear is catching steps with the treatment of the eye. It is knocking at the door of the Georgia School for the Deaf prepared to demonstrate beyond the shadow of a doubt that some of the inmates, even the congenital deaf, can be rescued.

Relieving deafness after it is established is a very much more arduous and doubtful task than preventing deafness by removing the cause at its inception. This latter is the work to which we need direct our best effort. To drive lurking deafness from the incipient diseases of the ear is the especial province of the general practi-

tioner of medicine. Let no physician lull himself into inactivity with the belief that his environment prevents him from participation in the aggressive movement tending to prevent disease. The finding of germs and spinning of fine scientific theories may call for special training and necessitate expenditures beyond the ability of the average doctor.

The work of preventing deafness brings the matter home to him on a simple and practical basis. The united and active interest of the physicians of this State in this matter would soon show beneficent local results. A concrete statement of such a crusade is for every doctor in Georgia to inform his patients of the good results to be obtained from early treatment of all diseases of the ears, of the serious after effects, of slight affections, and stress the necessity of early radical treatment to prevent deafness.

I hoped to have had in this paper a report from the last census showing the number of deaf people in Georgia from all causes. The census bureau has not finished the work of compiling this matter, so it will be deferred to another time.

Commendable State and professional pride and the cause of humanity should stimulate a desire to scale down these statistics, whatever they may be. The next report from this State should show a falling off of not less than a third in the number of deaf people.

Every doctor in Georgia should see to it that no one goes deaf within the scope of his jurisdiction because of lack of the knowledge that slight affections of the ears is a serious matter and should have attention promptly.

The public is quick to reflect the attitude of the medical profession relative to diseased conditions, and herein lies the hope of a quick response to a crusade against any disease. If the decree goes forth from the physicians of this State that all ear affections are to have early radical treatment, the people will respond, good results will follow, and when the next report is made it can be confidently expected that Georgia will show a lower percentage of deaf people than any other State.

Dr. Barnhill says, if all the graves made by neglected care were lighted, cemeteries would need no other illumination.

THE CLINICAL EXAMINATION OF THE BLOOD IN DIAGNOSIS.*

By L. B. COOK, M. D.,
Stanford, Ky.

The blood as a means of diagnosis occupies a very unique place in medicine. In a few affections it furnishes a ready-in-hand diagnosis, and in others it may be as valuable as in the diseases that carry in the blood the diagnosis with them.

* Read before the Kentucky State Medical Society, May, 1901.

The blood is a tissue that can be successfully studied during life, and its intimate relation with all the other tissues, carrying life or perhaps death to every cell in the body, makes it important that we appropriate all the knowledge its study may disclose. We should be familiar with the physiology, morphology and pathology of the blood that we may differentiate the pathological from the healthy; and I shall, therefore, at the risk of being trite and prosy, give a meager analysis of the composition of normal blood. The average number of white cells is 7,500, red cells 5,000,000 per cubic millimeter, and any marked deviation from these numbers, except in the anemia of the old and the plethora of the new-born, is pathological. A parallel increase or decrease of hemoglobin with corpuscles gives index colors=1; an increase of hemoglobin gives index+1, and a diminution index—1. The five varieties of white corpuscles that aid in diagnosis are the large and small lymphocytes, the polymorphonuclear neutrophile, the eosinophile and the myelocyte. Leucocytosis is an increase of the leucocytes without diminution of the polymorphoneuclears; lymphocytosis is a relative increase of the lymphocyte without a total increase of the other varieties. We may in a measure project the degree of health, and in children the degree of development, as the polymorphonuclears predominate over the other varieties. The erythrocyte is of special diagnostic and prognostic value in differentiating diseases, but can never equal the leucocyte in the diseases to which I shall, in brief, call your attention.

Anemia.—Anemia is one of the most common affections of the blood, and may be defined as a diminution of the corpuscles or hemoglobin or both; the serum can only be temporarily diminished. A blood examination readily discloses the pathology enabling one to make a diagnosis of not only anemia, but also the degree of anemia and whether or not we have to deal with a secondary or fatal form. A mild form of anemia is characterized by a diminution of the hemoglobin and specific gravity; the severe form by polyleukocytosis, by changes in the staining properties of the red cell, by a less number of red corpuscles, by the macrocyte and microcyte, and by the nucleated red cells, viz.: the normoblast, the microblast and megaloblast. The presence of a large per cent. of normoblast in the circulation means a great number are thrown into the circulation, from the bone marrow, before maturing. They are young, red corpuscles, the home of which is the bone marrow in health and periphial circulation in those diseases that require corpuscular reproduction. Their presence indicates a heavy drain upon the system by hemorrhage or disease. They are of more favorable prognostic value than the megaloblast, which is never found in the circulation in health, but circulate in increased numbers in the pernicious and fatal forms of anemia. In severe hemorrhage the tissues supply the depleted serum, but the bone marrow cannot so rapidly supply the cellular elements, making the blood count very low. This may be of very

practical import in cases of injury, where it is often impossible to tell how much blood has been lost, and whether or not the patient is suffering from shock due to loss of blood, from concussion or from the mangled tissues. In either case there cannot be a shock without a concurrent low blood pressure, and if shock is due to hemorrhage, transfusion is the remedy, but if due to concussion, transfusion would increase the shock.

Pernicious Anemia.—The blood in pernicious anemia is pale and watery, the red cells do not generally fall into rouleaux and resemble the blood of the lower animals. The degenerative changes of the red cell are characteristic. They are large and oval, contrasting with the smaller washed-out chlorotic cell. The most striking characteristics are the decreased number of red cells, the average being 1,000,000, lymphocytosis, and the nucleated cell; the megaloblast, when more numerous than the normoblast, establishes the diagnosis per se.

Chlorosis.—The blood of the chlorosis is readily distinguished from pernicious anemia, but from grave secondary anemia it is more difficult. The blood count gives 4,000,000, index color low, contrasting with high index of pernicious anemia. A striking feature is the excessive pallor without material diminution of the red cell. Hemoglobin 40 per cent. or less. Oligochromemia is the distinguishing characteristic of chlorosis, and even this is not sufficient to make a diagnosis, though it aids in differentiating from diseases like pernicious anemia that have high per cent. of hemoglobin. The red cells are uniformly smaller and paler than in the secondary anemias where the red cells are more irregular in size and staining qualities; the chief diagnostic point may devolve upon the white cell, an increase of which would aid in excluding chlorosis from malignant disease and the different suppurations. Stengel has shown, however, that with the blood examination the history and course of the disease must be taken together before any diagnosis can be made.

Leukemia.—The blood in each variety of leukemia is specific in diagnosis, and in each type the blood is different. In no other disease can a blood examination be of more value, and, in fact, it furnishes the only positive diagnosis between Hodgkin's disease and leukemia. The pathology of both diseases, outside of the blood itself, is the same, and post-mortem fails to find any difference. A diagnosis in the myelogenous type can be made by the great number of myelocytes, and the lymphatic type by the lymphocyte. The presence of a large per cent. of the polymorphonuclears would exclude leukemia from leucocytosis. The red cells are somewhat diminished, but not sufficient to aid in diagnosis. The nucleated red cell is greatly increased, and may reach as high per cent. as in pernicious anemia. The myelocyte is found in great numbers—the least count always gives 100,000. They are larger than the other leucocytes, and give, therefore, the appearance of the blood as being composed mostly of myelocytes. The polymorphonuclears, lympho-

cytes and eosiniphiles are increased because there is a leucocytosis, but their percentage is not increased, the increase being in the myelocyte. The cell characteristic of leukemia is the myelocyte, and only by its presence can a diagnosis be made.

Lymphatic leukemia is conspicuous for the absence of both the myelocyte and the nucleated red cell, and the diagnosis must devolve upon the large per cent. (90) of lymphocytes. Malignant disease and tumors of spleen and kidneys might stimulate leukemia, but the leucocyte being the polymorphonuclear would readily clear the diagnosis. We have seen that the myelocyte is characteristic of the myelogenous leukemia, the lymphocyte of lymphatic leukemia, the megoloblast of pernicious anemia, the polymorphonuclear of leucocytosis, and eosiniphile, perhaps, of trichinosis. Leucocytosis is present in all inflammatory infections and aids in differentiating typhoid, tubercular and malarial infections from septicemia, peritonitis, appendicitis, endocarditis, meningitis, salpingitis and osteomyelitis. Inflammatory leucocytosis is the key that unravels the skein in those diseases that often have the same symptoms in common. In all tubercular serous inflammations the white cell count is in contrast from rheumatic and septic serous inflammations—where the white cells may number 40,000. Epidemic or sporadic cerebrospinal meningitis, due to the pneumococcus or influenza bacillus, has such an increase of the leucocytes that the blood reveals this disease from tubercular meningitis.

Serum Diagnosis.—The serum of the blood is employed to-day very extensively in diagnosis. The reaction of the different serums upon bacteria as manifested in the many infectious diseases, viz.: Malta fever, cholera, anthrax, dysentery, plague and typhoid fever is invaluable.

The Widal reaction of typhoid fever as a means of diagnosis occupies a very necessary place in the obscure and irregular cases. There are different opinions as to the serum dilution and the time for clumping in typhoid fever, but 1:20 dilution with a time limit of one hour appears to be very satisfactory, although a higher dilution, 1:100, may be necessary to make the test absolutely certain.

The blood of 95 per cent. of all cases shows clumping during the course of the disease. I shall not enter upon serum pathology, and its relation to immunity, natural and acquired, or to bacterial dissolution, agglutination and immunization, or the hemolytic reaction of the serum of one animal upon the corpuscles of different species. Time would forbid such an extended discussion. Neither shall I enlarge upon the diseases in which a blood analysis would aid materially in making a diagnosis, after mentioning the spirochete of relapsing fever and the filaria; however, I shall give a brief review of the disease the profession dubs malaria. It very appropriately falls under the title of this paper, as Leveran about twenty years ago found in examining the blood that malaria was not due to *mal-air*, but to a protozoan parasite, the lowest form of animal life.

This parasite completes the circle of its development in the red cell, and has also a cycle in the mosquito by which malaria is conveyed from one person to another. It is, therefore, an infection, and like all infections requires an agent to spread the disease. Vincent has observed cases in which the transmitting agent seemed to be plant lice and the pollen of plants. The blood shows the various stages of the protozoon development from the bright amemoid jelly dots throughout pigmentation and sporulation. The spores are divided into the sporozoites and the gametocytes the sexual spores. The sporozoites multiply and develop in the red cell to rupture into the blood, and again multiply and repeat their invasion of the red cell ad infinitum. The gamtocyte does not undergo any further changes in the human body, but completes its cycle of development in the mosquito in about twelve days.

These cysts produce male and female spores, and these coalesce to form a new creature, the zygote, which divides into spores that have the power to move about till they reach the blood circulation, and are then carried to the salivary glands of the mosquito, ready to be injected into another person to begin a new cycle of malarial infection.

The blood reveals all these stages and also the different parasites by which we can differentiate the quotidian, tertian, quartan and estivoautumnal fevers. The protozoon parasite excludes many diseases, such as tuberculosis, meningitis, endocarditis and typhoid infection from malarial fevers.

It has not been my intention to give a minute blood analysis of the above mentioned diseases, but only a general outline of the more common pathological changes that attend them by which a diagnosis is made easier and often certain; neither shall I, with due respect for your patience, continue any further discussion of the diseases, the hematology of which is of less diagnostic value than in the diseases I have just recited.

A CLINICAL REPORT OF THIRTY CASES OF ACUTE LOBAR PNEUMONIA WITH TWENTY-NINE RECOVERIES.*

By Dr. E. D. NEWELL,

St. Joseph, La.

This series of thirty consecutive cases of lobar pneumonia, extended from April, 1898, to December 15, 1899. I make these specific dates not to include an unusually favorable termination of a special number of cases, and thereby falsify statistics, but I do so to represent the beginning of a special method of treatment, and the full time this treatment was used in a stated locality. This locality is King, Madison parish, my former field of practice. I would further emphasize why I have so specifically called attention to the time

* Read before the Louisiana State Medical Society, April, 1901.

during which these thirty cases were treated, and where they were treated, because in the same territory and under exactly the same conditions of season, race, poverty and ignorant attention from December 7, 1897, to April, 1898, I treated fifteen cases of lobar pneumonia with a mortality of 33⅓ per cent., but the medical treatment was entirely different.

It is usually conceded that pneumonia is more fatal during the winter and early spring than during the late spring, summer and fall months, and as my thirty cases extended through the spring and summer months, and the series of fifteen cases only extended through the winter months, it may be said that the season influenced the favorable results. However, 75 per cent. of the series of thirty cases occurred during the winter months. There are factors which are vastly more important in affecting the death rate than season, and these are age and sex. In the series of fifteen cases there are ten males and five females; of the males the ages were from fifteen to forty; of the females there were two children, one old woman and two young women. In the series of thirty cases there were ten females and twenty males, the ages of both sexes ranged from ten to forty-five years. This age under every method of treatment should give a more favorable death rate than the usual indiscriminate statistics. The average mortality of ten of the large American hospitals is 26 per cent., the mortality in private practice under favorable conditions is much less, and in military hospitals, where the patients are all young or robust, the mortality is less than in any other practice. Andrew Smith, of New York, claims that it is about 5½ per cent. In this series of thirty cases the mortality was 3⅓ per cent., under the most adverse conditions of race, poverty and ignorance. However, this very poverty may have favorably influenced the mortality, as all these patients lived in the well-known open negro cabin which permits the very freest circulation of air. Three-fourths of these patients I only saw twice during the attack, and none of them over one-half dozen times, although I would be consulted every day or two through the medium of friend or relative.

The treatment used in the first series of cases that had a mortality of 33⅓ per cent. was as follows: First day 5 to 8 grains of calomel, followed by saline cathartic, hypodermic injection of one-fourth grain morphin to relieve pain, and mustard jacket over consolidated area. If pulse was not over 120 per minute, 5 to 10 grains ammonium carbonate, combined with the usual cough remedies, were given every four hours. The nourishment, strictly liquid, was given every two hours regularly. Whisky was given every two hours during the day, and several times at night, two teaspoonfuls at first, and as pulse increased in frequency, the dose was increased. As soon as pulse increased to 120 or more per minute, I began with 10 minims of tincture of digitalis every four hours, day and night, and increased to 15 minims as the pulse grew faster and weaker. Temperature when 104° or above was reduced by cold sponging, otherwise no treatment was used to reduce temperature.

The treatment in the second series of cases that had mortality of $3\frac{1}{3}$ per cent. was very similar to the first series with the exception that strychnin was substituted for digitalis—no digitalis was given to relieve pain, a large mustard plaster over consolidated area, which was allowed to remain on long enough to thoroughly redden the skin, but never long enough to blister. Five to ten grains of calomel at one dose, followed by magnesium sulphate if bowels did not move freely. When temperature was not above 104° nothing was done to reduce it, but when it was above 104° the hands and face were bathed in cold water and three grains of acetanilid combined with strychnin and citrate of caffein were given, if patient was still very restless and had much fever. A strictly liquid diet was enforced on all the patients; this diet consisted almost entirely of milk, and patients were rigidly fed every two hours day and night during the latter stage of the disease when the pulse goes to or above 130; but during the first few days if the pulse did not go to 130 and was full and strong the patients were fed every two hours while they were awake, and only two or three times at night. In most of these cases on third or fourth day a second dose of calomel was given, and all during the attack the bowels were made to move once or twice a day with sulphate of magnesia. The strychnin sulphate (1–40 gr.) was begun on *first day in every case;* it was given every fourth hour *day* and *night*, this I insisted upon and told the attendants that if they forgot all other instructions and patient refused all other medicine he must be made to take the strychnin every four hours regularly. When pulse was 135 or above and was weak 1–30 strychnin sulphate was given every four hours, when above 145, 1–30 grain strychnin every three hours, and when 160 and scarcely perceptible at wrist and patient cold, clammy, dimly conscious, and panting for air, then 1–20 *grain strychnin every three hours was given, and one ounce of best whisky every two hours.*

I recall vividly a patient of this kind; his respiration was 80 per minute, pulse 160 and above, just a faint movement to be felt at all at wrist, cold perspiration saturating his clothes, the poor man panting terribly for breath; as he expressed it: "Doctor, I feel like I was running a long race." This was a muscular, robust negro of 25, and the only portion of his lungs not completely consolidated was the upper anterior portion of right lung. The patient made a good recovery. This one case that died was complicated with typhoid fever and I did not see her until the ninth day of illness. The following is a short history of her case: October 18, 1898—Clarence Washington, colored, female, aged 14, well developed, previous health good, has been in bed nine days, and *gradually growing worse;* has had fever continually, temperature 104 2–5°, pulse 110, respiration 36, tongue very dry and hard; bowels have not acted for two days, some few subcrepitant rales over both lungs posteriorly; physical signs did not indicate any consolidation, but patient was so weak I could not examine thoroughly for physical signs; no

pain in chest or side, but some cough and rusty-colored sputum. On the 19th, temp. 105 2–5°, delirious; pulse 120, tongue somewhat better. October 20, temp. 100°, pulse weak and fast. October 21, pulse 130 and very weak, temp. 102 4–5°. October 22, a. m., temp. 103°, very weak and delirious; p. m., 103 2–5°; died that night. As is usual with these cases, patient did not show marked signs of either disease, but the rapid respiration, rusty-colored sputum and sudden drop of temperature was sufficient to diagnose pneumonia; the other symptoms readily indicated typhoid.

Two of the cases I will call special attention to, as the treatment I used was entirely different from the treatment I used in the other twenty cases. In these two cases I used sodium salicylate and salol; this treatment was used with the hope and expectation that the sodium salicylate would abort the pneumonia by destroying the pneumococcus.

Case I.—Robust negro, aged 30, chill night of November 15, was playing cards in an open shed at the time, the chill was preceded by severe pain in the side and has had it ever since. Pulse 90 and not strong, resp 36, temp. 102, rales over lower lobe right lung, some rales on inspiration over lobe right lung, some rales on inspiration over lower portion of left lung anteriorly. Complains of pain all over, but more on left side; rusty-colored sputum very marked; considerable cough. Gave 10 grs. calomel; salol 5 grs. every four hours. Hypodermic of morphin was given at once for pain. November 16—Has rested beautifully since I left; is free from fever; resp. normal, pulse 72, but weak; sub-crepitant rales, all under left axillary space; rusty-colored sputum markedly present. November 17—Temp. 105 2-5, pain in left side severe; dry, hacking cough; he had a slight chill during the night; salol was continued, morphin hypodermically for pain. I began here with strychnin and whisky, as the pulse was weakened; also gave quinin, thinking that the patient might have malaria also. The next morning he was free from fever, respiration normal, and he made a rapid recovery without any further rise of temperature. I have never fully decided whether the second chill was due to malaria or relapse of the pneumonia that had been aborted; but I am rather inclined to attribute the second chill to relapse, as others have had the same relapses to occur where it could not be attributed to malaria.

Case II.—On November 16, 1898, I was called early one morning to see Thomas Lee, colored; aged 25; healthy, robust laborer. During the night he had a severe chill; this morning he had severe pains in left side, marked consolidation upper portion of left lung anteriorly and posteriorly. Has been suffering for two days with pains in stomach and abdomen, caused from eating partially cooked liver. Temp. 103½°, resp. labored, rusty-colored sputum; mustard to side; hypodermically morphin, 10 grs. calomel and three doses of sodium salicylate in one drachm doses to be given six hours apart. On 17th, pulse was 110 and fair, temp. 100°, resp. 36, perspiring

very profusely all over. Bowels acted well during night. Complains of but little pain, coughs very little; no bloody expectoration. Slept very little, but rested well. Continued sodium salicylate. On the evening of the 17th I saw him again, and he was perspiring so very profusely from the effects of the sodium salicylate that I had to discontinue it. November 18—Temp. 98 2–5°, pulse 86, very good, resp. 15, no pain whatever, sibilant and sonorous rales over consolidated area. Dullness was present, but not so marked as at first. When I discontinued the sodium salicylate I gave 5 grs. salol every four hours. November 19—Temp. 99 4–5°, pulse 72 and strong, resp. normal. A second dose of calomel was given. Throughout this attack he took whisky, but no strychnin was given. The distinctive feature of this case was that within thirty-six hours from the time he had the pneumonia chill all the severe symptoms had passed, and in sixty hours or less there were no symptoms whatever of the pneumonia, but the rales and slight dullness.

I did not use this treatment in any more of my cases, as it caused so much discomfort from the very profuse perspiration, the ringing in the ears and the decided weakened appearance of the patient. While he was under the influence of the sodium salicylate, of salol, the perspiration was so profuse that the patient's clothing had to be changed several times each day.

There were a few points of interest in these cases that I will call attention to, and the most notable one was that the pain was as often referred to the abdomen as to the side, and this is especially noted in my colored patients. The diagnoses of the cases was not at all difficult, the majority of these cases were diagnosed as soon as you saw patient, and in many cases you could easily tell the lung involved, as they almost invariably lie on the side affected. Every one of these cases showed rusty-colored sputum, but in some cases you had to examine sputum very carefully to detect the blood. Every one of these cases were examined thoroughly to detect the physical signs of consolidation and to confirm the diagnosis made from appearance and history. Some of these cases had one entire lung involved in the consolidation and a larger portion of the other one consolidated, and yet would not show symptoms of much distress, and you could not have made a diagnosis of pneumonia without the physical signs of consolidation. These cases invariably did well. There were cases in this series that showed profound invasion of the germs; you saw a patient with distressed, anxious and imploring countenance, eyes that would watch your every movement and follow you restlessly around the room, nostrils widely distended, cold, clammy perspiration over face, hands and body, breathing fast, shallow and painful temperature often not above 102½°, but pulse very weak and rapid. In these cases you would find usually but slight consolidation, one case in a convict camp only the lower portion of right lung was involved. These were the cases that were watched most carefully and where the strychnin and whisky were used to the fullest extent.

THE SUCCESSFUL TREATMENT OF ANÆMIA, WITH EFFECT SHOWN BY INCREASE OF RED CORPUSCLES AND HÆMOGLOBIN.*

By H. P. LOOMIS, M.D.,
New York City.

Dr. H. P. Loomis related a series of experiments to determine the value of Pepto-Mangan (Gude's) in the treatment of anæmia. It is a well-known fact, he said, that in the hæmoglobin of the red blood corpuscle manganese is always found. Opinions differ as to its significance. At the present time the majority of observers attribute to it an oxygenating function, some claiming that quantitatively it is more active than iron. It certainly gives off oxygen more readily than iron. Hence it has long been held that its introduction into the body would increase assimilation.

As early as 1838 Kugler recommended the manganese salts in scrofula, for he had noticed in chlorine bleaching establishments that those who handled the manganese salts enjoyed an immunity from diseases of the skin, bones or glands. For a long time, and by a number of observers, manganese has been recommended in anæmia and chlorosis, as it has been found by analyses of blood in these conditions that the manganese is diminished in some cases proportionately more than the iron. In spite of the high recommendation from various sources of the theoretical indication for manganese in anæmia it has not been extensively used on account of the difficulty which attended its absorption. The various combinations of iron and manganese which I have employed have yielded far from satisfactory results; almost invariably they have produced digestive disturbances after a short time.

Some time ago my attention was called to a new combination of iron and manganese, which was being extensively used in Germany. Extraordinary results were claimed for the preparation in chlorosis and anæmia by Professor Ruehle of Bonn and Dr. Ascher of Hamburg. I gave the preparation a careful trial, and the results obtained were exceedingly satisfactory. Believing, however, that the only accurate test of improvement in such conditions as anæmia is an increase in the amount of hæmoglobin and the number of red blood corpuscles, I made a series of examinations in regard to this point. In most of the cases in which the preparation was given the blood was examined before, during and after its use had been stopped. The Thoma Zeiss apparatus for counting blood corpuscles was used. At least three fields of sixteen squares each were counted from each specimen of blood, and the average number of corpuscles in each square obtained. In this way the number of corpuscles in each cubic millimetre of blood was estimated. This is the most accurate method of determining the number of corpuscles in a given quantity of blood with which I am acquainted. The normal number

* Read before the New York Academy of Medicine.

of corpuscles to each cubic millimetre of blood is estimated at 4,200,000.

The amount of hæmoglobin was estimated by Henocque's hæmatoscope, and also by the spectroscope. In normal blood there is about fourteen per cent. or fourteen grains of oxyhæmoglobin in each one hundred grains of blood.

To thoroughly estimate the advantages of the preparation eight persons with marked anæmia were selected, and careful notes of the cases taken while under treatment. No other medicine was given. In some of the cases the results obtained were much better than had previously been obtained with other preparations of iron.

The preparation of iron and manganese referred to is what is known as the "Liquor Mangano ferri Peptonatus Gudes" or, as is written on a prescription, Pepto-mangan "Gude"—a clear, dark sherry-colored neutral fluid, non-astringent and of mild aromatic taste, prepared by Dr. Gude, a chemist of Leipzig. The dose prescribed was a tablespoonful after meals in milk or in sherry wine. It is claimed that the combination of the iron and manganese with a peptone has decided advantages over the albuminate of iron in its permanency and ease of assimilation. Each tablespoonful of the mixture contained three grains of iron and one grain of manganese.

The following are the histories of the cases, with the results obtained:

Case I.—D. G., female, aged 78, entered Bellevue Hospital suffering with pelvic cellulitis, the symptoms of which disappeared at the end of a week. The patient was fairly well nourished, but with an excessively pale, waxy color. Examination of blood showed eight per cent. of hæmoglobin and 3,900,000 corpuscles to a cubic millimetre. After thirty-four days taking the preparation the amount of hæmoglobin had increased to eleven per cent. and the corpuscles to 4,800,000.

Case II.—E. W., aged 17, had the most profound anæmia after recovering from a severe attack of scarlet fever. Examination of blood showed six and one-half per cent. of hæmoglobin and 2,533,000 corpuscles to a cubic millimetre. After taking the preparation forty days the amount of hæmoglobin had increased to ten per cent. and the corpuscles to 4,500,000.

Case III.—A. W., female, aged 22, had been excessively anæmic for over a year; complained of headache, ringing in ears, dizziness, neuralgic pains, no organic lesion. Blood showed seven per cent. hæmoglobin and 3,520,000 corpuscles to a cubic millimetre. The corpuscles themselves were changed, some being microcytes and poikilocytes. After twenty-three days the treatment was stopped as the hæmoglobin was normal in amount and the corpuscles had increased to 5,000,000 to each cubic millimetre. The result in this case was the most pronounced of any.

Case IV.—Charles M., aged 21, sub-acute pleurisy lasting six weeks, very anæmic; no fever, some loss in flesh. Had taken syr.

ferri iodidi for a month, with but slight improvement in general appearance. Hæmoglobin eight and one-half per cent.; corpuscles 3,800,000 to each cubic millimetre. At the end of twenty days, when the treatment was stopped, the hæmoglobin had increased one and one-half per cent. and the corpuscles to 4,300,000; the fluid in the chest had disappeared.

Case. V.—F. B., female, aged 22, was admitted to the hospital suffering from insufficiency of the mitral valve. Presented the pale and anæmic appearance seen in cardiac disease. After the patient had improved so that she was up and about the ward she was put on the pepto-mangan (Gude). The examination of the blood at that time showed eight and one-half per cent. of hæmoglobin and 2,600,000 corpuscles to the cubic millimetre. After taking the preparation twenty-five days the hæmoglobin was eleven per cent. and the corpuscles 4,000,000 per cubic millimetre.

Case VI.—B. M., aged 24, suffering from primary anæmia and menstrual disturbances. No organic lesion. Hæmoglobin ten per cent., corpuscles 3,000,000 per cubic millimetre. After taking the preparation forty-three days the amount of hæmoglobin remained at ten per cent., but the corpuscles had increased 1,200,000 per cubic millimetre.

Case VII.—C. V., aged 15, presented the ordinary appearance of the anæmic girl at the age of puberty. No organic lesion. Hæmoglobin eight per cent., corpuscles 2,800,000. The examination of the blood after taking the pepto-mangan (Gude) forty days showed that the hæmoglobin was normal in amount and that there were 4,000,000 corpuscles to each cubic millimetre of blood.

Case VIII.—M. M., female, aged 24; six weeks after ovariotomy; presented a markedly anæmic appearance. Had shown a slight improvement in color after taking Blaud's pills for three weeks. These were stopped and the iron and manganese preparation given. Examination of blood showed eight per cent. hæmoglobin and 3,200,000 corpuscles per cubic millimetre. After forty-eight days the hæmoglobin had increased two and a half per cent. and the corpuscles 1,300,000.

In most cases the pepto-mangan (Gude) had no constipating effect. Of the eight cases in which accurate notes were kept, all showed a marked improvement both in the increase in the amount of hæmoglobin as well as increase in the number of red blood corpuscles. The average increase of the hæmoglobin was 2.2 per cent. and of the red blood corpuscles 1,258,000.

GALL STONE IN THE COMMON DUCT: ITS FREQUENCY, SYMPTOMS, DIAGNOSIS AND TREATMENT.*

By D. H. DUNNING, M.D.,

Indianapolis, Ind.,

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The writer quotes from the recent paper of Mosher, whose compilation of the Johns Hopkins Hospital records show that gall stones are present in 6.94 per cent. of our population and that 13 per cent. of all cases of gall stone the calculus is arrested in the common duct.

For convenience of description the author adopts the generally accepted classification of gall stone in the common duct, viz.:

1. The acute form in which there is acute obstruction, transient jaundice and the typical gall stone colic.

2. Chronic obstruction of the common duct from lodgment of a stone somewhere in the course of the duct.

The first division represents the old classical form of bilious colic and the symptoms are so well known they need not be given in detail.

In chronic obstruction from gall stone the jaundice is more or less intermittent and there is pain in the hypochondrium, epigastrium and back. The pain is not so severe as in acute obstruction and is very irregular. It may be located in the epigastric or lumbar region. As a rule there is absence of a tumor in the gall bladder region, but marked soreness. There is marked loss of weight and frequent chills and intermittent fever.

Treatment.—The Carlsbad cure, a sojourn at the French Lick Springs, large draughts of oil, the application of hot fomentations to the hypochondrium, and opiates to relieve pain are all of benefit in the acute cases.

The chronic cases are amendable to surgical treatment alone. The author cites and remarks upon the various methods of surgical procedure. Choledochotomy was shown to be the most approved method when applicable. The middle third of the duct is the point of choice for the incision. When the stone is in the duodenal end of the duct it can usually be crowded back into the middle portion and removed through an incision in that part.

An incision through the cystic duct may be carried onward into and through the common duct if the upper portion be chosen for the line of incision. Duodeno-choledochotomy is applicable to cases of a large fixed stone in the duodenal extremity of the duct. This method yields a higher rate of mortality than simple incision of the choledochus. Only soft stones should be crushed and needling is unsatisfactory. The writer would reserve cholecystenterostomy in

* Read before the American Association of Obstetricians and Gynecologists, at Cleveland, O., Sept. 18, 1901. Author's Abstract from The Amer. Gyn. and Obst. Journal.

common duct obstruction to those cases in which the patients could not endure the longer operation of choledochotomy.

Four cases are reported in detail, a very brief abstract is as follows:

Case I.—Mr. E., age 40 years. Subject of periodical attacks of gall stone colic for several years. The present attack began three months ago. Jaundiced from the beginning. The intensity of the jaundice being intermittent. There were intermittent chills and fever.

Upon operation there was found a single soft stone in the common duct. The gall bladder was normal in size and contained no stone. There were many adhesions, in the separation of which an opening was torn in the portal vein. Profuse hemorrhage followed. An attempt to close the opening in the vein by sutures was unsuccessful. Finally the anterior wall of the vein around the hole was picked up with thumb and finger and ligature thrown around it and tied. This was effectual in closing the hole and checking hemorrhage. The soft stone in the common duct was crushed. The patient recovered and was cured.

Case II.—The patient a woman 64 years old, a subject of gall stone colic for several years. Present attack began five weeks previous to operation. Patient very ill. Cholemia and purpuric spots upon the skin. She was profoundly jaundiced. Tongue dry and intellect clouded. Unfavorable case. Operation October 7th, 1900. Gall bladder small and packed with stones. Cystic duct was stenosed. Two small stones fixed in first third of common duct. Could not crush them or move them with the finger. The cystic duct was dilated with a slender forcep and there was a free flow of bile into the gall bladder. The gall bladder was joined to the colon by Murphey's Button. Patient bore operation well, but died at the end of 36 hours, probably of cholæmia.

Case III.—Mrs. B., aged 61. Former history of gall stone colic. Present attack of six weeks' duration. Intermittent jaundice. Irregular pains. Marked emaciation. Chills and fever. Gall bladder small and contracted around a mass of stones. One large stone in common duct. Choledochotomy. Recovery.

Case IV.—Woman, 53 years. History, attack of gall stone colic, extending over several years. Present attack began five weeks previous to my visit. Not deep, but varied jaundice. Pain in right hypochondrium. Occasional chills and intermittent fever. Upon operation found numerous gall stones in the gall bladder and three stones in a dilated portion of the common and hepatic ducts. Cystic duct was patulous. It was widely dilated and gall stones pressed out of the dilated portions of ducts. Patient recovered.

REPORT OF A CASE OF RUPTURED ECTOPIC GESTATION SUCCESSFULLY OPERATED UPON IN A TENEMENT HOUSE.*

By ABRAM BROTHERS, B.S., M.D.,

New York,

Visiting Gynecologist, Beth Israel Hospital; Adjutant Professor of Gynecology, N. Y. Post-Graduate Medical School and Hospital.

The object of presenting the specimen and report of this case before a medical society is not to encourage major operations in tenement houses. Any operator of even the smallest experience will readily testify that the properly equipped hospital is always the proper place for major surgery. Hospitals are built for this purpose. Operating rooms are laid out and provided with the necessary paraphernalia for modern aseptic surgery. Sterilizers, operating table, nurses and trained assistants are at hand for every operation. Emergencies are anticipated under the watchful care of the hospital staff and cumbersome allies like oxygen and transfusion apparatus are at the patient's disposal at a moment's notice.

Although the city of New York is supplied with a profusion of good hospitals readily accessible for emergency work—at any time night or day it happens from time to time that a patient's condition forbids removal or the patient simply but positively elects to die quietly at home rather than submit to transferral to a hospital. It was just this combination of circumstances which induced me to give the subject of the present report the benefit of the only thing to save her life—namely: a laparotomy in a tenement house.

Dr. M. Ghertler, through whose courtesy I saw this patient, has secured the following facts in the history of the case: Mrs. K., 37 years old, and married 16 years, has had three children and three miscarriages. The first miscarriage occurred three months after marriage; the second two years ago, and the third one year ago. Her menstruation began at the age of 15 years and has always been regular.

Five months ago her menses ceased, and, after remaining absent for two months, she began to spot irregularly. She considered herself pregnant and when, shorly afterwards, she began to bleed profusely, a physician was called in. He removed a "mass" with clots and pronounced the case a miscarriage. She was kept in bed eight days and, her condition being considered perfectly satisfactory, her physician ceased making visits.

She was up and about for a day or two when she was suddenly taken with cramps and pain in the lower right abdominal region. This was accompanied with fainting spells, yawning, occasional vomiting, and clammy perspiration. Dr. Ghertler was sent for and found the patient in collapse. Recognizing the alarming condition of the patient a consultation was hastily determined on and six hours later we examined the case together with the following result:

* Read by title at the meeting of the Eastern Medical Society, held Oct. 11th, 1901.

The patient—a large, heavy, flabby woman—was pulseless. Her face was white and, although perfectly rational when spoken to, she lay with eyes half closed in a condition of syncope. The heart-beats were very rapid and barely perceptible. The abdomen was inflated and her respiration was of a sighing character. There was no hemorrhage from the vagina and a bimanual examination showed absolutely nothing. This examination, by the way, was very unsatisfactory because of the long vaginal canal, thick abdominal wall and the bloated condition of the intestinal tract. The diagnosis of ruptured extrauterine pregnancy was made to be confirmed, if an operation was decided upon, by an exploratory vaginal puncture.

Having explained the state of affairs to the husband with the necessity of immediate operative intervention the precaution was taken of adding the possibility of a fatal result occurring as a result of moving the woman to the hospital. Still it was urged that the woman's chances of recovery after operation would be vastly better after she had safely been brought to the hospital. The patient in the adjoining room had overheard a portion of the conversation and refused point-blank to leave her home. She preferred to take the chance of dying in her own bed.

Under the circumstances, as the husband and friends were ready to live up to all other conditions, it was decided that the only thing left was to operate upon the patient in her own rooms. These consisted of one small bedroom, one kitchen and one room facing the yard. We selected the kitchen as the operating room with one gas-jet and a lamp for purposes of illumination. The kitchen table was placed between the range and the wash-tubs and we closed our eyes to the usual dust and dirt which surrounded us on all sides.

On my summons Drs. Rabinowitch and Heller brought over sterilized gauze, towels and aprons from the Beth Israel Hospital and Drs. Ghertler and Friedman prepared instruments and patient for aseptic work with the assistance of two nurses.

The patient was placed in the lithotomy position on the kitchen table and while Dr. Ghertler carefully gave the anesthetic, Drs. Rabinowitch and Heller at once proceeded to make an intra-venous infusion of salt solution. With the assistance of Dr. Friedman I seized the cervix in tenaculum forceps and, with a sharp-pointed scissors, punctured the peritoneal cavity through the posteria vaginal fornix. At once a stream of dark-colored liquid blood began to flow and our diagnosis was absolutely confirmed. Hastily introducing a strip of gauze into this wound and packing the vagina with more the patient was drawn up on the table in the horizontal posture and the abdomen rapidly opened. A large quantity of free and clotted blood at once escaped. The right adnexa were brought up and showed a large vent in the Fallopian tube and a cystic ovary the size of a plum. This was removed and the pedicle secured in a running catgut suture. The opposite adnexa were examined and proved to be normal. After washing out the peritoneal cavity with several pitch-

erfuls of hot water the abdominal wound was closed without drainage and the patient was put to bed.

After the operation the patient developed symptoms of pulmonary congestion and required several transfusions of salt water for threatening heart failure. Camphor given hypodermatically was responsible for two abscesses in the right thigh which required attention later. After the first two or three days, however, convalescence was smooth and the patient left her bed on the 28th day entirely well.

112 East 61st Street.

OSTEOMYLETIS INVOLVING THE METACARPAL BONE OF THE MIDDLE FINGER.

Surgical Clinic of Dr. N. Senn, Chicago, Ill.

This is the patient upon whom we operated a week ago to-day for a limited central osteomyletis involving the metacarpal bone of the middle finger. I will remove the dressing to-day for the first time. The disease was characterized by intense pain which was referred to the site of the infection, the central osteomyletis giving rise to considerable swelling outside of the bone; and skiagraph came in this instance to our aid in not only making a pathological but a very accurate anatomical diagnosis. The skiagraph that has been passed around shows near the lower articular end of the metacarpal bone, corresponding to the epiphyseal line, a light spot, which indicates the exact location of the suppurating focus. We suspected in this case a tubercular infection, and we had every reason to believe so from the clinical history of the case. However, the age of the patient, as I informed you at the time, spoke against such a diagnosis, and we found on opening the bone with a small gouge a small cavity in the centre of the bone occupied by two or three drops of creamy pus. We made a culture at the time, but I have not yet learned the result. I hope to be able to report it to you at the next clinic. I am satisfied, however, that the culture will show the staphylococcus pyogenes aureus or albus, a microbe which so often gives rise to a limited osteomyletis. As I predicted at the time, the patient was relieved promptly immediately after the operation, because we succeeded in removing the cause of pain—tension. The patient has not suffered since the operation, and I will remove to-day the iodoform gauze drain for the first time. You will note that there is absolutely no indication of suppuration. The wound has healed by primary intention, which is largely due to the thorough mechanical removal of the infected tissue by the use of chisel and sharp spoon, followed by aration of the fundus of the uterus from the location which it now occupies. The wound has healed, as you will notice, by primary intention throughout. We will reseal the wound to-day, reapply a similar dressing, and postpone the removal of the stitches for at least another week.

COLLE'S FRACTURE.—I have shown you many cases of Colle's fracture in the aged during the present winter, but it is not often that I can exhibit to you a case of a similar accident in a child. This boy fell a week ago directly upon the palm of the hand. Note the appearance of the wrist-joint to-day. We have a typical silver-forked deformity in this case, a subluxation of the lower end of the ulna, the seat of the fracture being about three-quarters of an inch above the wrist-joint; deviation of the lower fragment backward toward the dorsal side of the arm; lateral and posterior displacement of the lower fragment—a typical Colle's fracture. I shall recommend that this boy be brought into the hospital. I am informed that only two weeks has elapsed since the accident. If we administer a general anesthetic I am satisfied that we shall be able to break up, by mild manual force, the existing adhesions between the two fragments, effect reduction, and consequently secure a good result. The ulna is not fractured. In the majority of cases in children we find both the radius and ulna are fractured. Here the ulna is intact but subluxated.

HERE IT IS IN A NUTSHELL

A **Stimulant** excites vital action, a **Tonic** supports vital action, but a **Food** repairs the waste caused by vital action.

"The body derives its **energy** from the **food** it assimilates. **Fat** contains more energy than any other kind of food."
PROF. WM. H. HOWELL, M.D., PH.D.

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EDITED BY

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SECRETARIES OF MEDICAL SOCIETIES will do us a favor by keeping us informed of dates of meetings of same, etc

THE FATE OF THE SURGEON.

With the intellectual calm that accompanies ignorance of danger, the surgeon of to-day is playing with a fire that will shortly, unless checked, involve both the guilty and the innocent in the most effective punishment for folly that evolution has produced—namely, extinction of the species. The growing practice of paying the general practician a secret fee for bringing a case, just as the knowing contractor secretly fees corrupt public officials, bids fair if persisted in for a few years to make surgery so unprofitable a specialty that its followers will be compelled to turn for a living to general practice. In very self-preservation surgeons must unite to stop this "commission business."

As has before been pointed out, this pernicious practice leads to one certain and inevitable end—the general practitioner bartering his cases about till he finds the surgeon who will treat him the most liberally. Other surgeons will be compelled to go without work or to meet the commissions offered by their competitors, and in a very brief space of time surgical fees will have fallen to an unprofitable level. This tendency of the commission evil to reduce the surgeon's fee is already being appreciated, but very shortly it will be felt most keenly.

The surgeons are still at a stage in the evolution of this practice when they can choose their future course. Shortly, choice will be impossible, and necessity will work out its own inexorable result.

If the surgeons wish to preserve their specialty, to retain the means of making a livelihood, and to preserve the entire medical profession from years of public scorn, they will immediately unite among themselves to once and forever put a stop to this suicidal practice. If *laissez faire* is to be their motto, they will when the end comes at least have the satisfaction of knowing that they deliberately chose the easier way which led to extinction.

Like ostriches, many of us who see no special harm in giving and receiving commissions, are inclined to think that if the matter is not discussed in the medical societies and medical journals the public will never discover what we are doing and that all will go along swimmingly. Leaving aside the rather cowardly immorality of this view of the subject, it is worth while to point out some present tendencies. Already we hear echoes of grumbles from less scrupulous general practitians who are dissatisfied with the commission received from the surgeon. Already a few, who have become angry at the surgeon, are telling their friends that he is corrupt and purchasable. Shortly these rumbles will increase in intensity as the earthquake approaches. The surgeon will awake to the fact that he has lightly placed his reputation entirely in the hands of one who now seeks by every means to injure him. The story of the commission told in the right place will do the rest. Can the surgeon afford to run this risk? Does not the common sense of self-protection unite with the insistent demand for a clean professional life to impress upon the surgeon to-day the imperative necessity of agreeing with his fellow to at once abolish a custom that thus threatens both honor and existence?

[The views of the editor of the Cleveland Journal of Medicine on the subject so thoroughly coincides with ours that we publish same in full.—Ed.]

THE OLDER WRITERS ON MALARIA.

Professor Grassi, one of the leading Italian authorities on malaria, was interviewed in 1900 by Drs. Manson and Sambon. The following answers were obtained to certain leading questions. The substance of these replies may be taken as representing the creed of the modern malariologist.

"Can a man contract malaria without being bitten by the mosquito?"

"No."

"Can a mosquito infect a mosquito?"

"No."

"How then do you account for the prevalence of malaria which is reputed to follow on turning up of fresh soil in malarial countries?"

"When you dig in the ground you make holes in which water is collected, and there Anopheles breed. Where men go, there Anopheles come."

"How is malaria in uninhabited countries to be accounted for?"

"We have no perfectly authenticated cases of such. In fact Sarrasin, in his recent interesting work on the Celebes, states that malaria is not contracted in the jungles, but only near the villages."

"No man, no malaria; no mosquito, no malaria. Is that your creed?"

"Yes, most decidedly."—*British Med. Jour.*, Feb. 10, 1900.

The very full discussion of malaria in "Watson's Practice of Physic," written 1836–37, may be taken to represent the views of the profession prior to the discovery of the plasmodium. Certain things were predicated of malaria in Watson's time, the truth of which is only confirmed by our exact knowledge of the parasite and the means by which human beings are infected. In the early part of the nineteenth century the word *malaria* became fashionable as a substitute for the term marsh miasmata. It was stated by Watson to be a *specific poison*, and not simply bad or impure air. He declares that ague in London is almost always imported; this corresponds to the absence of Anopheles from large cities. He was aware that malaria required a certain degree of moisture, but that excessive quantities of water prevented the disease. Excessively malarious districts in India can be traversed safely during or immediately after heavy rains, but they become very dangerous a few days later. He noted that the decomposition of vegetable matter was often associated with the malarial poison, but claimed that it did not produce it, as the miasm was known where there was no decaying vegetation.

Ferguson, an early nineteenth century writer on malaria, said that the most deadly conditions were those in which the surface was covered with water and then dried rapidly; precisely the conditions which late writers claim to favor the development of the malarial mosquito.

Watson fully recognized and emphasized the view that malarious districts were much more *dangerous at night.* Lancisi was aware of this, and devoted a chapter of his book to its study. A ship is spoken of that visited the Island of St. Thomas. The crew of 280 all went on shore hunting and fishing; they all returned to the ship at night, excepting sixteen men, all of whom had malaria, and thirteen of whom died. Only those who remained on shore at night had the disease. The following year the same ship at the same place lost eight or ten men who remained on shore over night. From these facts Watson deduces the practical rule: "In malarious countries the open air at night must be avoided. 'Early to bed' is a good and wholesome rule; but the other half of the proverb, 'early to rise,' becomes an unsafe precept in such countries. At least it is hazardous to *leave the house* early." It will be seen that Watson made a distinction between rising early and going out-of-doors.

The conveyance of the malarial poison by the wind was well understood; and the fact that it would not cross a stream of any width, or traverse a wood, was known. The relation of cultivation and

density of population to malaria were well known. The Italians date the introduction of malaria into the Maremma from the plague in the sixteenth century, after which the number of inhabitants became greatly reduced. Ruderpoor in India, after its devastation in 1805, became excessively malarious; prior to that time it had no malaria.

It will be seen from this brief presentation that the older views are quite in accord with the theory that malaria is a mosquito-borne disease. All the conditions that are now known to favor Anopheles were claimed by the older writers to favor the spread of malaria.*

EDITORS' TABLE.

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* Medicine.

were that their business had grown to such proportions that they desired to be where they could have better facilities for procuring the various ingredients that enter into the composition of the goods they manufacture. They say that their foreign business has grown to such proportions that there is scarcely a country in the world where educated physicians do not use their goods.

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Nothnagel's Encyclopedia of Practical Medicine.—Edited by Alfred Stengel, M.D., Professor of Clinical Medicine in the University of Pennsylvania; Visiting Physician to the Pennsylvania Hospital.

It is universally acknowledged that the Germans lead the world in Internal Medicine; and of all the German works on this subject, Nothnagel's "Encyclopedia of Special Pathology and Therapeutics" is conceded by scholars to be without question the best system of medicine in existence.

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The American edition will be more than a mere translation of the German; for, in addition to the matter contained in the original, it will represent the very latest views of the leading American specialists in the various departments of Internal Medicine. The whole system will be under the editorial supervision of Dr. Alfred Stengel, who will select the subjects for the American edition, and will choose the editors of the different volumes.

Unlike most encyclopedias, the publication of this work will not be extended over a number of years, but five or six volumes will be issued during the coming year, and the remainder of the series at the same rate. Moreover, each volume will be revised to the date of its publication by the American editor. This will obviate the objection that has heretofore existed to systems published in a number of volumes, since the subscriber will receive the completed work while the earlier volumes are still fresh. Review of Volume I, see page 238.

NEW BOOKS.

FROM W. B. SAUNDERS & CO.

Modern Obstetrics: General and Operative—W. A. Newman Dorland, A.M., M.D., Assistant Demonstrator of Obstetrics, University of Pennsylvania; Associate in Gynecology, Philadelphia Polyclinic. Second edition, rewritten and greatly enlarged. Handsome octavo, 797 pages, with 201 illustrations. Philadelphia and London: W. B. Saunders & Co., 1901. Cloth, $4 00 net.

The first edition of this book was received with almost unanimous expressions of approval by the medical profession. In the revised editions it has been entirely rewritten and very greatly enlarged, so that it now forms a complete text-book of obstetrics along the lines that make the original edition so useful. A number of entirely new sections have been added, including chapters on the surgical treatment of puerperal sepsis, and the role of the liver in the production of puerperal eclampsia. Especial attention is given to the more recent pathology of obstetric conditions; as well as to the physiology and hygiene of pregnancy and labor; a more accurate elabaration of the mechanism of labor has been adopted. By new illustrations the text has been elucidated, and the science of modern obstetrics is presented in an instructive and eminently acceptable form.

To get an idea of the scope of this work we will glance at the table of contents: Part I—*Physiologic Obstetrics* covers 219 pages and embraces the following subjects: The Generative Organs and Parturient Canal; Puberty and its Manifestations; Gestation; The Physiology of Pregnancy; The Clinical Manifestations, Differential Diagnosis and Hygiene of Pregnancy; Normal Labor; Puerperium and Management of the Newborn. Part II—*Pathologic Obstetrics* is considered, covering 157 pages, and considers Diseases of the Ovum and the Fœtal Appendages; Pathologic Condition of the Fœtus; The Pathology of Pregnancy.

The reviewer must confess that Dr. Dorland's idea of dividing the subject as above outlined is of great practical value. Since, clinically, the vast majority of labors are normal in almost every respect and *Physiologic Obstetrics* as a matter of course should most appropriately first command the attention of the accoucher.

Unfortunately, however, there are an immense variety of pathologic possibilities that may mar the features of this *physiologic* process at its successive stages, and these conditions are presented under the caption of *Pathologic Obstetrics.* The author in his evolution of the foregoing system of obstetrics has has observed every measure that will facilitate the aim of the student and the busy obstetrician. To insure ease of reference a system of paragraphing, italicizing and numbering has been adopted, and wherever possible carefully selected diagrams and illustrations have been inserted to still further illustrate the text. All measurements are given in both metric system and English equivalents. A large number of diagnostic tables

are inserted. The reviewer lays it down feeling sorry that there is not just a little more of it. We congratulate Mr. Saunders on the elegant style of paper and type and commend it to every student and practitioner.

Human Physiology—Prepared with special reference to Students of Medicine. By Joseph Howard Raymond, A.M., M.D., Professor of Physiology and Hygiene in the Long Island College Hospital, and Director of Physiology in Hoagland Laboratory, New York City. Second edition, entirely rewritten and greatly enlarged. Handsome octavo volume of 668 pages, 493 illustrations, 12 of them in colors, and 4 full-page lithographic plates. Philadelphia and London: W. B. Saunders & Co., 1901. Cloth, $3.50 net.

Since the first edition of this work scientific research has made such rapid progress in the study of human physiology that the author deemed it imperative entirely to rewrite the work. In the extensive revision the same general subdivision of the subject has been retained, adding, however, a section on Histology, which will be found fully adequate for a thorough understanding of the physiologic anatomy of the organs whose functions are under discussion. Special attention has been given to the influence of alcohol upon mouth and gastric digestion, to the subject of deglutition and the gastric movements as observed by use of the Rontgen rays, and to the physiologic significance of gastrectomy.

Internal secretion, thyroid treatment, blood coagulation, fat absorption, and the most recent contributions on the genesis of uric acid has been concisely, though thoroughly, considered.

Laryngeal photography, by Professor French, and the subject of voice production have been extensively discussed, elucidating the text by numerous well-selected illustrations.

In the portion of the volume devoted to the Nervous Functions many changes have been introduced, necessitated by the general acceptance of the "neurone theory;" and the section treating on the senses of sight and hearing have also been greatly elaborated.

In the discussion of the Reproductive Functions stress has been especially laid upon the divergent views regarding the relation of menstruation to ovulation.

In every way the new edition of this most valuable work is highly commendable. It will be found useful and practical, not only to the student, but also to the practitioner, as an up-to-date book of clear, concise, accurate information.

In the author's 20 years' experience as a teacher of physiology to medical students it has brought him to the conclusion that in the short time allotted to the study of physiology in medical schools students can only grasp the main facts and principles of the branch of medicine which lies at the very bottom of a sound knowledge of the healing art. In his teaching and writings the author has kept this thought constantly before him, and in this manual has endeav-

ored to put in a concrete and available form the results of his experience. Students desiring a fuller knowledge of the human functions are referred to the *American Text-Book of Physiology*, where they will find the subject discussed in extenso by leading physiologists of the present decade. This is a very handy, concise, practical exposition of the subject, and as such we commend it to the profession.

The Principles of Hygiene—A Practical Manual for Students, Physicians and Health Officers. By D. H. Bergey, A.M., M.D., First Assistant, Laboratory of Hygiene, University of Pennsylvania. Octavo volume of 495 pages, illustrated. Philadelphia and London: W. B. Saunders & Co., 1901. Cloth, $3.00 net.

This book is intended to meet the needs of students of medicine in the acquirement of a knowledge of those principles upon which modern hygienic practices are based, and to aid physicians and health officers in familiarizing themselves with the advances made in hygiene and sanitation in recent years. The book is based on the most recent discoveries, and represents the practical advances made in the science of hygiene up to date.

Among the important subjects considered are Ventilation, Heating, Water and Water Supplies, Disposal of Sewage and Garbage, Food and Diet, Exercise, Clothing, Personal Hygiene, Industrial Hygiene, School Hygiene, Military and Naval Hygiene, Habitations, Vital Statistics, Disinfection, Quarantine, etc. The idea of the book is to give the reader a clear understanding of the general principles of this broad subject. The rapid strides made in our knowledge of the entire subject has rendered such a book, reflecting the more recent discoveries, a necessity to physicians and students of medicine.

No attempt has been made to treat the subject in an exhaustive manner, the object being merely to give the general principles upon which the health officer and physician work in their respective capacities in dealing with conditions which are detrimental to health, or which tend to improve health. The metric system of weights and measures has been employed throughout the work, since this system is now employed in all the scientific laboratories in the United States, and because it is in every way preferable to the cumbersome and complicated system with its various units now in common use. The appendix explains the relative value of weights and measures of the metric system, and gives the equivalent in the English system. This is a very practical work and one that we commend.

American Edition of Nothnagel's Encyclopedia—Volume I, Typhoid and Typhus Fevers—By Dr. H. Curschmann of Leipsig. Edited, with additions by William Osler, M.D., Professor of the Principles and Practice of Medicine, Johns Hopkins University. Handsome octavo of 646 pages, illustrated, including a number of valuable temperature charts and two full-page colored plates. Philadelphia

and London: W. B. Saunders & Co., 1901. Cloth, $5.00 net; Sheep or Half Morocco, $6.00 net.

The reviewer has been anxiously awaiting the appearance of Volume I of this, *the greatest system of medicine ever produced.* The publishers advise us that the system, when complete, will be a set of 12 volumes, representing the essence of *Nothnagel's* original encyclopedia, and the purchaser will obtain at less than half the cost the cream of the original. The volumes will appear one about every two months, each volume revised to date of publication. The last volumes will be received while the first are still fresh.

The original German edition of this volume is universally recognized as the standard authority on the subjects of which it treats. The American edition, however, even surpasses the German, for, besides containing all the material of the original, extensive additions have been made to almost every chapter, thus incorporating into the work the very latest views on the subjects under discussion.

The chapter on Bacteriology has been thoroughly revised and much new material added, giving prominent consideration to the distribution of the typhoid bacilli, especially in the urine, the rose-spots, and the blood.

To the chapter on Pathology many minor additions have been made, incorporating the important work of Mallory. The literature on the localized lesions due to the bacillus has been carefully reviewed and made to conform to the most recent advances in that part of the subject. Thayer's exhaustive study of the state of the blood has been utilized, and the Surgical Aspects of Typhoid Fever have been fully revised with the aid of Keen's monograph.

Much valuable material has been added to the chapter on Diagnosis by Bacteriologic Methods, particularly with reference to the recent work in blood-cultures and on the detection of bacilli in the urine.

The chapter on Perforation and Peritonitis has been practically rewritten, as has also the section on the Hepatic Complications of Thyphoid.

Thus it will be seen that the American edition of this valuable work, while still possessing all the commendable qualities of the original German, is greatly enhanced in the field of usefulness by being brought strictly abreast of the latest literature on the subjects, and by representative specialists.

Dr. Osler has made many additions to the original and presents the work Americanized fully abreast with the teachings of the best writers both of this country and Germany. The publishers realizing the merit of this excellent system have given it all the art in bookmaking for which they are justly famous.

Pathological Technique—A Practical Manual for Workers in Pathological Histology, including Directions for the Performance of Autopsies and for Clinical Diagnosis by Laboratory Methods. By

Frank P. Mallory, A.M., M.D., Associate Professor of Pathology, Harvard University Medical School; and James H. Wright, A.M., M.D., Instructor in Pathology, Harvard University Medical School. Second Edition, Revised and Enlarged. Octavo, 432 pages, with 137 illustrations. Philadelphia and London: W. B. Saunders & Co. 1901. Cloth, $3.00 net.

In revising the book for the new edition the authors have kept in view the needs of the laboratory worker, whether student or practitioner, or pathologist, for a practical manual of histological and bacteriological methods in the study of pathological material. Many parts have been rewritten, many new methods have been added, and the number of illustrations has been considerably increased. The majority of the latter are beautiful original photomicrographs of various species of bacteria.

Among the many changes and additions to this edition may be mentioned the amplification of the description of the Parasite of Actinomysosis and the insertion of descriptions of the Bacillus of Bubonic Plague, of the Parasite of Mycetoma, and Wright's methods for the cultivation of Anærobic Bacteria. There have also been added new staining methods for elastic tissue by Weigert, for bone by Schmorl, and for connective tissue by Mallory.

This book is designed especially for practical use in pathological laboratories, both as a guide to beginners and a source of reference to the more advanced. This work will meet the wants of the busy practitioner, who has the inclination or opportunity to do general pathological work. The authors go into the technique of laboratory work in bacteriology and pathologic history, giving methods and fomulæ which have proven of the greatest service in practical work.

The new edition of this valuable work keeps pace with the great advances made in pathology, and will continue to be a most useful laboratory and post-mortem guide, full of practical information.

A Text-Book of Pharmacology.—Including Therapeutics, Materia Medica, Pharmacy, Prescription Writing, Toxology, etc. By Torald Sollmann, M.D., Assistant Professor of Pharmacology and Materia Medica, Western Reserve University, Cleveland, Ohio. Royal octavo volume of 880 pages, fully illustrated. Philadelphia and London: W. B. Saunders & Company. 1901. Cloth, $3.75 net.

This work aims to furnish, in a manner suited for reference and study, a scientific discussion and definite conception of the action of drugs, as well as their derivation, composition, strength and dose. The author bases the study of therapuetics on a systematic knowledge of the nature and properties of drugs, and thus brings out forcibly the intimate relation between pharmacology and practical medicine. Practitioners and students will find the work an admirable guide in that most important part of their equipment, namely, how to use drugs accurately and efficaciously. The book includes the

practical subjects of materia medica, pharmacy, prescribing, incompatibility, toxology, pharmacognacy and prescription writing. The more important subjects are made prominent by the use of display type. When the views of different observers vary and when several theories are advanced stress is placed on those only which deserve preference. In many instances theories, which account for a number of facts, are likewise specially noted. Frequent cross references are introduced to avoid repetition or making the book unwieldly. Drugs, somewhat similar in physiologic action, are arranged into groups—to each group is attached a short section treating of its therapeutic action and application. This is further supplemented by numerous compilations of drugs which may be used to secure a good result.

A special chapter has been devoted to toxicologic analysis, including both the inorganic and organic poisons. Pharmaceutic assaying has likewise been given due consideration. There is also a section on laboratory experimentation, which, besides rendering the greatest aid to the student in the laboratory, will serve as a basis for classroom demonstrations. The book will be of the utmost service, not alone to students and practitioners, but also to druggists and every one interested in the use of medicines.

Saunders' Medical Hand-Atlases—Atlas and Epitome of Bacteriology. A Text-Book of Special Bacteriologic Diagnosis. By Professor Dr. K. B. Lehmann, Director of the Hygienic Institute in Wurzburg; and R. O. Neumann, Dr. Phil. and Med., Assistant in the Hygienic Institute in Wurzburg. From the Second Enlarged and Revised German Edition. Edited by George H. Weaver, M.D., Assistant Professor of Pathology, Rush Medical College, Chicago. In two volumes. Part I, consisting of 632 colored figures on 69 lithographic plates. Part II, consisting of 511 pages of text, illustrated. Philadelphia and London; W. B. Saunders & Co. 1901. Cloth, $5.00 net.

This work supplies a long-needed want in the field of bacteriology and bacteriologic diagnosis, and proves a most valuable addition to Saunders' Series of Hand-Atlases. As in all the volumes of this commendable series, the lithographic plates are accurate representations of the conditions as actually seen, and this well-selected collection, if anything, is more handsome and useful than any of its predecessors. As an aid in original investigation the value of the work is inestimable.

The text is divided into a general and a specific part. The former furnishes a survey of the properties of bacteria, together with the causes of disease, disposition and immunity, reference being constantly made to an appendix of bacteriologic technic. The special part gives, so far as possible in a natural botanical arrangement, a complete description of the important varieties, the less important ones being mentioned when worthy of notice. The causes of diph-

theria and tuberculosis, together with the related varieties, have been given especial attention.

Most praiseworthy is the reformative tendency in regard to the grouping of varieties of bacteria, the strict division of the system especially, the rational naming of the bacteria, etc. The system of nomenclature is entirely original with the authors and is deserving of the greatest commendation, particularly that of the fission-fungi, which has been handled in a most masterly manner.

As a text-book of bacteriology and bacteriologic diagnosis it is all that could be desired, embracing, as it does, in a comparatively limited space, all the important species and many of the less valuable ones, and discussing them in language concise and easily intelligible.

One of the most valuable features of these atlases is that they offer a *ready and satisfactory substitute for clinical observation.* Such observation, of course, is available to the residents in large medical centers, and even then the requisite variety is seen only after long years of routine hospital work. To those who are unable to attend important clinics these books will be absolutely indispensible, as presenting in a complete and convenient form the most accurate reproductions of clinical work interpreted by the most competent clinical teachers. That these Atlases now appear in *thirteen different languages* is proof of the fact that this class of literature is appreciated. Messrs. W. B. Saunders & Co. issue them on good paper and give them a handsome dress in dark green buckram.

A Laboratory Handbook of Physiologic Chemistry and Uterine Examination.—By Charles G L. Wolf, M D., Instructor in Physiologic Chemistry, Cornell University Medical College, New York. 12mo volume of 190 pages, fully illustrated. Philadelphia and London; W. B. Saunders & Co. 1901. Cloth, $1.25 net.

The object of this book is to supply to students and practitioners of medicine a guide to a course in physiologic chemistry and the examination of the uterine and the contents of the stomach. The first part of the book is taken up with simple exercise in physiologic chemistry, which will give an elementary insight into the chemical side of physiologic processes. As will be seen from a glance at the table of contents, first the author gives the physiologic chemistry of the carbohydrates, fats, protein substances and blood. The digestive fluids and products of digestion are next considered, with chapter on examination of stomach contents.

Next analysis of the urine is taken up, including volumeric methods and total solids.

In the part of the book which deals with the urine and gastric contents, no tests have been given which do not rest on good chemical foundation. The aim has been to give as few tests as possible, and these to be chosen for their suitability to purely clinical needs. No operations are described which have not undergone a thorough trial with students in the laboratory.

First Aid to the Injured and Sick.—By F. J. Warwick, B.A., M.B., Cantab., Associate of King's College, London; Surgeon-Captain, Volunteer Medical Staff Corps, London Companies, etc.; and A. C. Tunstall, M.D., F.R.C.S. Ed., Surgeon-Captain Commanding the East London Volunteer Brigade Bearer Company; Surgeon to the French Hospital and to the Children's Home Hospital, etc. 16mo volume of 232 pages and nearly 200 illustrations. Philadelphia and London: W. B. Saunders & Co. 1901. Cloth, $1.00 net.

This volume of practical information is intended as an aid in rendering immediate temporary assistance to a person suffering from an accident or sudden illness until the arrival of a physician.

The importance of first aid is indisputable as a life-saving expedient, for upon the promptness and efficiency of the aid first rendered the patient depends, in a great measure, the termination of the case.

The authors, fully appreciating the urgency of the subject, have succeeded in producing an admirable work of practical emergency procedures, and they have couched it in such clear and unequivocal language that even those entirely unfamiliar with the science may easily grasp the meaning intended.

It will be found a most useful book of ready aid, and of invaluable service, not alone to nurses, railway employes, etc., but also to the laity in general, as a book of indispensible first aids.

FROM D. APPLETON & CO.

A Text-Book of Medicine for Students and Practitioners.—By Dr. Adolph Strumpell, Professor and Director of the Medical Clinique at the University of Erlangen. *Third American Edition* translated by permission from the *thirteenth* German edition by Herman F. Vickery, A.B., M.D., Instructor in Clinical Medicine, Harvard University, and Philip Coombs Knapp, A.M., M.D., Physician for Diseases Nervous System, Boston City Hospital; with Editorial Notes by Fredrick C. Shattuck, A.M., M.D., Visiting Physician Massachusetts General Hospital; with 185 Illustrations and one Colored Plate. Cloth Binding; 1213 Pages. Cloth Binding, $6.00. D. Appleton & Co., Fifth Avenue, New York City.

Strumpell has a reputation among those familiar with German literature as an author of prominence, and this translation from the thirteenth edition of his work on the Practice of Medicine will be welcomed by the English speaking members of the profession. Since the appearance of the second American edition, in 1893, seven new editions have appeared in Germany, which has afforded the author an opportunity to incorporate, as far as practicable, the many important of the latest results in scientific progress, so that the book has been almost wholly rewritten, although it still retains all the merits of the earlier production. The translators have kept as close to the original as consistent with clearness, the doses in the metric

system have been changed to the approximate equivalent in the apothecary system, the original doses being retained in parenthesis.

In this revision the author has made an effort to place the work upon a level with contemporary medical thought and knowledge. Large portions of this work have been wholly rewritten, in particular the whole subject of Gastric and Intestinal Diseases, and several chapters in other sections, including Gall Stones, Hepatic Disorders and Intestinal Parasites. Almost all sections of the book, not wholly rewritten, have received numerous additions and improvements, so that the whole work has been completely revised.

The translators add a valuable chapter upon the *Plague*, and various notes [inclosed in brackets] followed by initials of translators to distinguish them from the [unsigned] additions of the editor—Dr. Shattuck.

The subject of Typhoid Fever is considered at great length. The author believes in the early administration of calomel, but says: "As yet a remedy to destroy the specific cause of the disease is yet unknown," "and antiseptics, none of which have proved to be of value, and we cannot advise future trial of them."

The subject of Malaria, in all its types and manifestations, is disposed of in a chapter of nine (9) pages. Perhaps the reason for saying so little about such an important subject is that in Germany the disease usually runs a mild course and gives little annoyance, but practitioners in the South find it a big proposition to go up against and want a book which goes into the subject of malaria with more thoroughness in detail and treatment.

This, from a critic's standpoint, is the only fault we find with the work.

The book, it may be said, is all it claims to be, and really deserves a kind reception at the hands of practitioners and students.

Typography and illustration leave nothing to be desired. The Appletons turn it from the press adorned with all the art in bookmaking, for which they are justly famous.

The Principles and Practice of Medicine Designed for the Use of Practitioners and Students of Medicine.—By William Osler, M.D., Fellow of the Royal Society; Fellow of the Royal College of Physicians, London; Professor of Medicine in the Johns Hopkins University and Physician-in-Chief to the Johns Hopkins Hospital, Baltimore, etc. Fourth Edition. New York: D. Appleton & Co. 1901. $5.00.

The fourth edition of Osler's excellent work merits all the commendation which has been given the previous editions. The time has long since gone by when even a book of 1,150 pages, by so eminent authority, can supply the needs of the physician as a reference work in all the subjects of which it treats. As a book for students, as a compact and useful compend for physicians, and as an expression of Dr. Osler's own opinions—on a wide range of subjects—the book

is of the greatest value. The third edition has undergone a thorough, painstaking revision. The work is thoroughly up to date. The article on Typhoid Fever has been partly rewritten; the subject of Malaria has been recast and new matter added on Etiology and Prophylaxis. The subjects of *Dysentery*, *Yellow Fever* and the *Plague* have been rewritten, the author not forgetting the needs of the physicians practicing in the tropics. These subjects are up to date, which the rapid progress of our knowledge of these subjects demand.

The subjects of Pneumonia and Diphtheria, Small-pox, Cerebro-Spinal Fever, Rheumatic Fever and many of the acute infections new points are added on diagnosis and treatment. A good deal of material has been added on the subjects of Diabetes and Gout, Obesity, Arthritis, Deformans and many others.

Infectious diseases occupy the first 350 pages; then come Animal Parisites, Arthritis, Deformans, Gout, Rheumatism and Obesity, and are among the interesting problems in medicine. Their being put together in the class of constitutional diseases is in the nature of a confession of our ignorance of their real cause. Diseases of the digestive and respiratory systems, and of the circulatory system, and diseases of the blood and ductless glands, and of the kidneys follow, and the book closes with the diseases of the nervous system, to which 250 pages are devoted.

The orthography and terminology is that adopted by standard lexicographers. This is a book for the desk and not the shelf. It is one of the best books on practice that we have examined in a long time, and to commend this volume is both a pleasure and a duty. To Dr. Osler the profession are under many obligations, and to the publishers, who appreciate a good work, we commend their business tact and rare sagacity for placing this work before the profession in a style worthy of its contents.

FROM LEA BROTHERS & CO.

A Manual of Surgical Treatment—By W. Watson Cheyne, A.B., M.B., F.R.C.S., Professor of Surgery in the King's College, London; Surgeon to King's College Hospital and The Children's Hospital, Paddington Green, and F. F. Bughard, M.D. and M.S., London, Teacher of Practical Surgery in King's College, London; Surgeon to King's College Hospital, Paddington Green. In seven volumes. Volume III covers Surgical Affections of the Bones and Amputations. Cloth Binding. 295 Pages. 100 Illustrations. Price $3.50. Volume IV embraces the Treatment of the Surgical Affections of the Joints (including excisions). Cloth Binding. 360 Pages. 138 Illustrations. Price $3.75. Lea Brothers & Co., Philadelphia and New York City. 1901.

The subject of surgery covers such a widely diversified branch of medicine that any work attempting to deal with it in an exhaustive manner must necessarily be large and unwieldly and suitable only

for purposes of reference, or for those who devote their whole time and attention to this study. The authors, realizing the comprehensiveness of such large works, have thought it wise to prepare in a series of manuals containing the literature of the subject in text-books of convenient size, each covering certain branches of the subject.

In Volume III the first eight chapters, covering 169 pages, are devoted to fractures. Simple, compound and complicated each are described in minute detail, together with the most modern methods of treatment for all fractured bones that enter into the bony framework of man. Chapters 9 to 16 are devoted to "Diseases of Bones," embracing acute and chronic inflammation of bones, necrosis tuberculous disease of bones, syphilitic and rheumatic affections of bones, rickets, osteo-malasia, arthritis, deformans, leontiasis, ossium, acromegalny and tumors of bone.

Next we see chapters XV, XVI and XVII, covering amputations, general considerations, amputations in upper extremity and amputations in lower extremity.

The authors teach the skin flap methods and outline all methods and after treatment.

Fractures of the skull, the spine, the jaw, hyoid bone and ribs have not been included in this volume. The authors only mention the methods of treatment which they have found of most practical value. Necessarily many well recognized methods are not mentioned.

In Volume IV the first nine chapters are devoted to dislocations, covering 75 pages, beginning with general considerations. Following this will be noticed a brief description of symptoms and treatment of dislocation of clavicle, shoulder, elbow, wrist and fingers, hip, the knee and its cartilages, ankle and foot.

Chapters X and XI are devoted to sprains and wounds of joints. The next seven chapters cover diseases of joints in general, in inflammatory affections of joints, tuberculosis of joints, syphilitic and nervous affections of joints, loose bodies and anchylosis of joints. Next we notice disease of individual joints, diseases of hip, knee, ankle and tarsus, shoulder and elbow, wrist and hand. Following next are the surgical affections of the spine, injuries of the spine, spina bifida kyphosis, scoliosis, spondilitis, hyterical spine and sarcocygeal tumors.

These two volumes are of special interest to the surgeon and general practitioner. The descriptions of the surgical treatment of the diseases and injuries to the parts under consideration in these two volumes are clearly and plainly written, with a profusion of well-drawn illustrations to assist the text. This manual of seven volumes forms a most complete library of *Surgical Treatment*, prepared by authors each eminent in his field. Each volume has a splendid index.

Anatomy, Descriptive and Surgical.—By Henry Gray, F.R.S., Lecturer on Anatomy at St. George's Hospital, London. Thoroughly revised American from the 15th English Edition. In one imperial octavo volume of 1246 pages, with 780 illustrations. Price, with illustrations in black, cloth, $5.50 net; leather, $6.50 net. Price, with illustrations in colors, cloth, $6.25 net; leather, $7.25 net. Lea Brothers & Co., 709 Sansom Street, Philadelphia. 1901.

When a book undergoes fifteen (15) editions, it must be accepted that its popularity. has demanded frequent editions; for forty-five years Dr. Gray's masterpiece has held front place among works on anatomy.

In this edition the work has undergone a careful revision. The section on embryology has been amplified and its text rendered more intelligible by the addition of sixty additional illustrations. Throughout the work many changes and additions are found, diagrams redrawn and illustrations added.

A revision of Gray's Anatomy interests every student of medicine. It is a perennial favorite, and with good reason. Henry Gray was doubly a genius, being equally a born anatomist and a born teacher. His methods of presenting anatomical knowledge in text and picture were such a conspicuous and rational advance in his first edition that it instantly won the foremost place, which has never since been disputed.

The foremost anatomists have been engaged in the many successive revisions, of which the present is perhaps the most thoroughgoing. Every page has been scrutinized and whole sections written, notably those on the brain, spinal cord, nervous system and viscera. The magnificent and unique series of illustrations has been enriched with 231 new engravings, and the use of colors have been greatly increased.

Thus this great work is again brought up to date with lavish expenditure of labor and money. It is probably the cheapest of all products of the press, considering the fact that it contains the ripest anatomical knowledge of the world presents it with an unequalled wealth of illustration.

Essentials of Obstetrics.—By Charles Jewett, A.M., M.D.,Sc.D., Prof. of Obstetrics and Gynecology in the Long Island College Hospital, and Obstretrician and Gynecologist to the Hospital, etc. New (2d) edition, revised and enlarged. In one 12mo. volume of 376 pages, with 80 engravings and 5 colored plates. Cloth, $2.25 net. Lea Brothers & Co., Publishers, Philadelphia and New York.

The early exhaustion of the first edition of Dr. Jewett's practical and compendious little work is very satisfactory proof of its value and helpfulness.

Its object is to place the essential facts and principles of obstetrics within the easy grasp of the student, and to aid him in follow-

ing the lectures and practical teaching of his college course. To this end its language is simple, every statement is clear cut, its arrangement is systematic and logical and illustrations are freely used. Works of this character have a distinct value in medical teaching. Once the student masters the elements in any branch, a complete and systematic knowledge becomes a matter of comparatively easy growth.

This is a very practical, helpful volume, just the book the student needs. The subject matter is covered in fewest possible words, concise, clearly and to the point. We heartily commend it.

A Manual of Practical Hygiene for Students, Physicians and Medical Officers.—By Charles Harrington, M.D., Assistant Professor of Hygiene in the Medical School of Harvard University. Illustrated with 12 plates in colors and 105 illustrations. Handsome octavo volume. 721 pages. Cloth Binding, $4,25. Lea Brothers & Co., Philadelphia and New York. 1901.

In preparing this Manual of Practical Hygiene, the object of the author was to provide a book to meet the needs of students of medicine, practitioners and health officers. The subject, in its entirety, covers such a broad field that the author wisely omits certain topics which are discussed in larger works. For instance of late it has been the custom to incorporate in works on hygiene a chapter on elementary bacteriology. Inasmuch as special text-books cover this and allied subjects, which the author recognizes as an essential to the equipment of the modern medical practitioners; therefore the reader will turn to special works in which the science is fully treated.

Chapter I opens with a resume of foods, general considerations, carbo-hydrates and hydrocarbons, beverages, condiments, spices, bakers' chemical food preservation, and contamination of meats. Next the author considers such subjects as air, the soil, water, habitations, schools, etc., ventilation and heating, lighting and plumbing, sewage and garbage and their disposal, disinfectants and disinfection, quarantine, military, naval and marine hygiene, hygiene of occupations, vital statistics, personal hygiene, care of body, regulation of diet, rest and recreation, physical exercise and dress, vaccination; and the last chapter considers disposal of the dead.

Subjects which come more properly within the fields of engineering and architecture, such as the construction of aqueducts and sewers, the nature and strength of building materials, the arrangement and construction of hospitals, etc., have been left to works on these respective subjects. The book is based on the most recent discoveries, and represents the practical advances made in the science during the past few years.

The Medical News' Visiting List for 1902.—Weekly (dated, for 30 patients); Monthly (undated, for 120 patients per month); Perpetual (undated, for 30 patients weekly per year). Each style

in one wallet-shaped book, with pocket, pencil and rubber. Seal Grain Leather, $1.25. Thumb-letter Index, 25 cents extra. Philadelphia and New York: Lea Brothers & Co.

For nearly half a century the one published by Lea Brothers and their predecessors has been a favorite. Revisions have been made through a series of years, until any further change would be neither desirable or practicable. Besides the blank daily records, it contains tables for converting the ordinary weights and measures into the metric system, the Fahrenheit scale into centigrade; instructions for the examination of the urine; important incompatibles, artificial respiration, poisons and antidotes, a very complete posological table in both systems of weights and measures, and a very handy list of several pages of therapeutic reminders, directions for ligation of arteries. In the back it has a patented thumb-index for general memoranda, obstetric engagements, vaccination, deaths, addresses, and last but not least a cash record bound in seal grain leather; right size; wears well.

FROM P. BLAKISTON'S SON & CO.

Hemmeter—Diseases of the Intestines.—Their Special Pathology, Diagnosis and Treatment. With Sections on Anatomy and Physiology, Microscopic and Chemic Examination of the Intestinal Contents, Secretions, Feces and Urine; Intestinal Bacteria and Parasites; Surgery of the Intestines; Dietetics; Diseases of the Rectum, etc. By John C. Hemmeter, M.D., Philos. D., Professor in the Medical Department of the University of Maryland; Consultant to the University and Director of the Clinical Laboratory; etc. In two volumes. Volume I—Anatomy, Physiology, Intestinal Bacteria, Methods of Diagnosis, Therapy and Materia Medica of Intestinal Diseases, Diarrhea, Constipation, Enteralgia and Enterodynia, Meteorism, Dystripsia, Enteritis, Colitis, Dysentery, Intestinal Ulcers, Intestinal Neoplasms, etc. With many original illustrations, some of which are in colors. Published by P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia. 1901. Large octavo, 740 pages. Price, $5.00 per volume.

That a work of such magnitude and thoroughness should be the product of an American author is a matter for special congratulation; for in America no such rewards are obtained as in the older countries. This work stands to-day without its equal in England, Germany, France or Italy, and in a special line, too, when the French and German schools are claiming the best of everything.

This work of Hemmeter's differs from all other works on the subject, because it contains a number of entirely new methods of diagnosis; it gives credit to American clinicians in this special department, and shows in every way a vast deal of original personal work of unquestioned value.

He treats the subject systematically and concisely, giving first anatomy and physiology of the intestinal tract, the methods of diag-

nosis, therapy and materia medica of intestinal diseases, including dietetics; following this with a methodical discussion of the following subjects:

Constipation, Enteralgia and Enterodynia, Metorism, Dyspepsia, Enteritis, Colitis, Dysentery, Intestinal Ulcers, Intestinal Neoplasms, giving symptomatology, diagnosis, prognosis, pathology and treatment.

The author's aim in presenting this work is to furnish the practitioner with a complete work from which he may readily instruct himself concerning the most approved modern methods of diagnosis and treatment of intestinal diseases. It will be seen, upon a careful examination of the work, that the author has entirely covered the field of modern literature on the subject, deducting therefrom the scientific advances which promise help in diagnosis and treatment.

We think this work is the best on the subject in our language. It treats of many subjects in an original manner and is not only based on a considerable personal experience, but gives due honor to other well-known workers in this special field of work. For reference or information on all new points it is a necessary work to the physician who would keep up with his profession.

Messrs. P. Blakiston's Son & Co. have realized its genuine worth and do full credit from a publisher's point of view. The illustrations and press work are to be commended.

A Handbook of the Diseases of the Eye and Their Treatment.—By Henry R. Swanzy, A.M., M.B., F.R.C.S.I., Examiner in Ophthalmology to the University of Dublin; Surgeon to the National Eye and Ear Infirmary, and Ophthalmic Surgeon to the Adelaide Hospital, Dublin. Seventh Edition. Revised and Enlarged. With 165 illustrations, one Plain Plate and a Zephyr Test Card. Published by P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia. Cloth, $2.50 net.

This is really a handbook of diseases of the EYE. The author very wisely omits the anatomy of the eye, and at once takes up abnormal refraction and accommodation, teaching the use of the trial test case, the ophthalmoscope, its indications and uses. Next are considered diseases of the conjunctiva, of the cornea, of the eye-lids, of the Lachrymal apparatus, of the nasal tract and of the sclerotic, of the crystaline lens, of the vetrios humor, of the retina and of the optic nerve. Next, the author considers those diseases of the eye liable to accompany focal and organic disorders of the brain; and next, those liable to result from diseases and injuries of the spinal cord, and ending with an appendix which points out the defects of vision which disqualify candidates for admission into civil, naval and military government service.

Altogether it is a very practical work, with a good index, makin it a valuable reference book to the ophthalmologist and a useful boo to guide the general practitioner in handling diseases of the eye For the student and general practioner this is the book to buy.

The Physicians' Visiting List for 1902, published by Messrs. P. Blakiston's Son & Co., Philadelphia.

We are pleased to see that there is a tendency to cut out some of the medical literature that has been finding its way into books. Most of this matter is out of place here and uselessly cumbers the volume. What has been retained in this list will prove a convenience to the physician, but more still might be omitted. It is not, or should not be, necessary for the phsyician to carry about with him rules for treating asphyxiated persons, for reducing the readings of different thermometers, or for ascertaining the day when labor may be expected. The suggestions in metric prescription writing and the table of doses in apothecary and metric systems are useful in the attempt to popularize the latter. The list has the usual departments for daily records and various memoranda. It is bound in flexible cover and the price remains the same—25 patients a week, $1.00; 50 patients a week, $1.25; the same in two volumes, $2.00; perpetual, $1.25.

FROM F. A. DAVIS COMAANY.

The Medical Bulletin, Visiting List or Physicians Call Record, Arranged upon an original and convenient monthly and weekly plan, for the daily recording of professional visits by George Ben Johnson. New and revised edition. No. 1.—Regular size to accommodate seventy patients daily each month for one year. Bound in Heavy Red Leather, pocket size, $1.25. The F. A. Davis Co., Philadelphia, Pa.

It is not necessary to remind you, Doctor, that you will need a new visiting list for 1902. The above is a favorite with a great many physicians. It is so arranged that you only need to write your patient's name but once during the month, having three narrow leaves to record the visits on, following the name and place for address, street and number. Among other practical points we find a handy table of fees, obstetric table, for foretelling the day of confinement, a table for calculating the number of doses in a given ℞, the number of days it will last, etc. Table for converting apothecaries' weights and measures into grammes; a table giving number of minims to fluid drachms. Formulæ and doses for hypodermic medication, formulæ and doses of medicine for inhalations, poisons and antidotes, periods of eruption of the teeth; the pulse, a very handy posological table, arranged for single and daily doses, and in addition it has blanks for addresses of nurses, obstetric record, bills and accounts, cash record.

FROM DODD, MEAD & CO.

Warwick of the Knobs, a Story of Stonington County, Ky.—By John Uri Lloyd, author of "Stringtown on the Pike," "Etidorphia," "The Right Side of the Car," etc., with photographic illustrations of Knobs County. Dodd, Mead & Co., New York City. 1901.

This is a story of a strange people and a curious form of life in Stonington County, Kentucky, the scene of which is laid during the war of the rebellion. "Warwick of the Knobs" is a tragedy so full of pathos, so human, so thoroughly characteristic and dramatic that it is destined to assume the dignity of a romance that will live in literature. It is a tragedy made terrible by religious dogmatism that wavered not in the face of misery, disgrace and death, a dogmatism that stood erect and firm among the human wrecks that crumbled at its feet. Around this strange character of "Preacher Warwick" is weaved the tragedy of grief, a story of love and war and passion that stirs men's souls to the horror of religion as practiced by "Warwick," who stands before the reader convicted yet exciting intense admiration. "Preacher Warwick" is a type of what was commonly known at that period as the "hard shell Baptist." His religion was a tower of strength that could not be moved, much less shattered. He served his God with a devotion that was heroic and came into relation with his fellow beings with more dogmatism than human instincts. A daughter that nature had made beautiful, entirely ignorant of the world, yet craving for its healthy pleasures, falls an easy prey to an infamous plot of a young Northerner right under the eyes of old "Warwick." "Joshua," the girl's brother, is seen in the early stages of the book an ignorant country boy, but under the series of curses that befall the "Warwick" family "Joshua" goes North to seek retribution from, or the life of the man who has brought dishonor to their home. To attempt to portray more of it would take away from the reader the pleasure of following the careers of the stirring characters of the book. Prof. Lloyd's tale is more fact than fiction. It will draw the fire of religious criticism and attain the enthusiastic defense of thousands of churchmen. "Warwick of the Knobs" is undoubtedly the strong book of the year.

FROM THE ABBEY PRESS.

Her Royal Highness Woman—By Max O'Rell. Cloth, 12mo., 311 pages handsomely bound in silk cloth, with a photo frontispiece of the author. $1.50. Published by Abbey Press, 114 Fifth Ave., New York City.

This book, written in a terse, epigrammatic style, full of human philosophy, and dealing with woman, love and matrimony, proves that a Frenchman can write on these delicate subjects without running the risk of offending the most delicate ears. It is piquant, but as refined as it is amusing and instructive.

We are sure that this book, the author's latest, on the eternal feminine will be welcomed by the great American public.

Max O'Rell is perhaps the best known and the most widely popular writer in his field now living. His name and fame are international and cosmopolitan, like his tastes and habits. Familiar with life everywhere, he is competent to describe it anywhere, and he has a special insight (almost a second sight) where the fair sex are concerned.

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MARION X. CORBIN, M. D.,
SAVANNAH, GA

MERCURIAL INUNCTIONS VERSUS INTRAMUSCUAR INJECTION IN THE TREATMENT OF SYPHILIS.—C. F. Marshall, in The Lancet of August 24, 1901, says that a comparison of the different methods of treating syphilis is difficult, owing to the length of time which the cases must be under observation. His comparison of the value of intramuscular injections and inunction in the treatment of syphilis is based upon 69 cases which were under continuous observation while he was resident medical officer at the London Lock Hospital, most of the patients being under treatment for more than a year. Thirty-seven of the cases were treated by intramuscular injections and thirty-two by inunction, during the active symptoms of secondary syphilis. When the active symptoms had cleared up the patients were put on a course of pills.

The method of intramuscular injection was that introduced by Mr. J. A. Bloxam. Ten minims of a solution of sal alembroth containing one third of a grain of the salt was introduced by means of a platinum iridium needle thrust deeply into the muscles of the buttocks. The injections were given once a week, first upon one side and then upon the other.

The inunctions were made with gray ointment composed of one part of mercury, one part of lanolin, and one-half part of olive oil. About one-half of this was rubbed daily into different parts of the body, the rubbing lasting about twenty minutes, a warm bath being taken before each inunction.

There were sixteen relapses of the disease during or after treatment by intramuscular injection, including no less than four cases of severe iritis and one case of early tertiary syphilis. Of the thirty-two cases treated by inunction, there were only seven relapses, two of which were doubtful, and only one case of iritis. The results in these cases justify the conclusion that relapses are twice as frequent with the injection treatment as with the inunction method.—*Medicine.*

CHLORETONE IN EPILEPSY.—D. J. McCarthy, in the International Medical Magazine for August, 1901, finds in chloretone an excellent

substitute for the bromides, in cases where they have failed of the desired effect or where for any reason they cannot be administered. A patient is described, aged 48, who had epileptic attacks at irregular intervals, and who had been taking bromide in half-drachm doses for a year. He was unable to perform his usual work because of the mental torpor and lack of concentration which the bromides produced, and could not give up their use because of the return of the attacks. In this case chloretone in fifteen-grain doses gave excellent results, with none of the depressing effects of the bromides. In a group of cases in which the bromide failed to relieve the epileptic seizures, chloretone sometimes gave excellent results. In the case of a woman with Jacksonian epilepsy secondary to a migraine, beginning early in childhood, the bromide failed to relieve the spasm of the head, neck and arm. Chloretone was substituted in fifteen-grain doses at night, which was later reduced to seven and a half grains, with no return of the trouble. Previous to the administration of the chloretone the attacks occurred several times weekly under large doses of the bromides. In some cases of true epilepsy where the bromides had little if any effect, the seizures ceased entirely for a time under chloretone.

The writer concludes that in chloretone we have a drug which in selected cases is an excellent substitute for the bromides. It gives good results under decreasing doses, after the primary effect is obtained. The drug is given in capsules, and the dose is sufficient in the beginning to produce a hypnotic effect. In that large class of epilepsy in which the fits occur only at night, chloretone is of especial value in reducing the number of seizures. The dietetic, hygienic and constitutional treatment is to be rigidly enforced in conjunction with the administration of the chloretone.—*Medicine.*

Methylene Blue in Malarial Disease, and the Substitution of Methyl Blue for Methylene Blue.—Dr. Achilles Rose (Post-Graduate, September) reports the case of a girl, 15 years of age, suffering from malarial affection, the principal manifestation of which were daily headaches and right supraorbital neuralgia. Percussion over the right eyebrow caused pain even during the interval between malarial attacks, while such percussion on the left side caused no pain. Quinine, ten grains at night and five grains in the morning, gave no relief, but the administration of methylene blue caused the disappearance of the symptoms. Dr. Rose explains this fact as follows:

In the year 1891 Ehrlich and Guttmann recommended methylene blue in the treatment of malaria, because they had found that the malarial parasites took up this dye; that they had an election for it. And, indeed, Guttmann observed that the parasites disappeared from the blood gradually while methylene blue was given; that the patients were cured by the destruction of the plasmodia. The reports of all observers confirmed the fact of disappearance of the parasites under methylene blue treatment. It was found that the protoplasm

of the parasites shrank, became compressed and were colored blue, but that the methylene blue did not act on the nuclei of the plasmodia, and, finally, that there existed an antagonism between the action of methylene blue and quinine—namely, that quinine destroyed the nucleus of the parasite, its chromatin, and methylene blue the plasma.

Now we know that methylene blue will have a curative effect in those forms of malaria in which the plasma is most developed and quinine in those in which the nuclei are the most developed and the plasma more or less wanting. The form which is most decidedly affected by methylene blue is that of the crescents, which consist almost entirely of plasma, while on the other hand juvenile forms of plasmodia which have very little plasma remain unaffected by methylene blue, but are very sensitive to quinine. The full-grown parasites, the principal part of which consists almost entirely of plasma, are indifferent to quinine, but most sensitive to methylene blue; they are completely destroyed by it.

The author then comments on the occasional substitution by druggists of methyl blue for methylene blue, and warns physicians to be careful in specifying the drug and especially to avoid abbreviating the name. He had has several unsatisfactory experiences in such substitution, even with high-class firms, and gives the following test by which the two can be distinguished: A dilute aqueous solution of methyl blue becomes decolorized on the addition of ammonia water, while a solution of methylene blue, even when very dilute and light colored, is not so decolorized.—*N. Y. Med. Journal.*

Mrecury and Iodide of Potassium Given Internally with Pilocarpine Hypodermically in Diseases of the Eyes.—The employment of mercury and iodide of potassium internally given with pilocarpine hypodermically in disease of the eyes has given such satisfactory results in so many of his cases that Burnham (Lancet, April 27, 1901) feels justified in advocating the superiority of this combined treatment. Its efficacy is probably dependent on its power to arouse to excessive activity, in a vigorous and sustained manner, the normal physiological processes in diseased tissues, thus acting in accord with the efforts of nature to bring about a restoration to a normal condition.

In one of the cases described there was found at the upper and inner part of the eyeball in the ciliary region very severe scleritis, limited, the patch of exudation being large, swollen and deeply congested. The adjacent cornea was infiltrated with a cloudy opacity up to and slightly beyond the pupilary margin, and there was much pain, photophobia and other symptoms. Mercury and iodide of potassium were given for ten days, and atropine was used locally. The severity of the symptoms was lessened, but the progress of the sclerokeratitis was not stayed. In nearly a month the scleritis was more extensive, and the cornea was infiltrated almost throughout its whole

extent. Pilocarpine was then given daily in doses of one-sixth of a grain for two weeks, and then at intervals of from four to six weeks for seven injections, one each day. In about three months the sclerokeratitis was cured, but there was left a decided corneal haze. The treatment was no longer necessary for the scleritis, but it had to be kept up so as to clear up the cornea and thus restore normal vision. At the time of the report of this case an almost or entire normal vision was expected. The appearance of the formerly severely inflamed sclera was normal. The prognosis regarding this form of sclerokeratitis has always been gloomy, but under the combined treatment described a permanent curative effect may be secured.

A second case suffered from acute sympathetic ophthalmia. For nearly eight months this patient had taken internally five grains of iodide of potassium thrice daily after eating, and the twenty-fourth of a grain of bichloride of mercury before eating. One-tenth of a grain of pilocarpine was given hypodermically every second day after the first two weeks for five months continuously. During the remainder of the eight months at the end of every two weeks there was given an injection every second day for six injections, which were continued. The apparent result will be for all practical purposes an eye normal as regards vision and its general condition.

Burnham has been employing this treatment in a case of double conical cornea with very encouraging success.—*Therapeutic Gazette.*

Antistreptococcus Serum in Erysipelas.—MacMillan (British Medical Journal, March 9, 1901) injected ten cubic centimeters of antistreptococcus serum (Jenner Institute) in a severe case of erysipelas of the face and scalp. Feeding and medicinal treatment were almost impossible owing to persistent vomiting before the injection. The morning after the first injection ten cubic centimeters more was injected, and in the evening there was considerable improvement as regards the intensity of the erysipelas, and the sickness had much improved. At the same time the whole scalp had become involved, the temperature was at 101.6°, and the pulse at 110. The next morning another 10-cubic-centimeter injection was made; during the day sickness passed off entirely, food was well taken, and the swelling and tenderness were greatly reduced. In the evening the temperature was 99.4°, and pulse 102. The patient had an excellent night, and the next morning the face and scalp were free from tenderness except at the back of the head. From this point recovery was rapid and continuous.

Abortion was threatened for a week before the onset of the illness, but this was safely tided over and quickening was felt at the normal time.—*Therapeutic Gazette.*

INTERNAL MEDICINE AND NEUROLOGY.

UNDER THE CHARGE OF

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THE PATHOLOGICAL AND CLINICAL STUDY OF 120 CONSECUTIVE CASES OF ACUTE LOBAR PNEUMONIA WITH POST-MORTEM EXAMINATIONS.—John L. Steven, in the New York Medical Journal of August 10, 1901, (Medicine, Nov.) gives an analysis of 120 cases of acute lobar, or croupous, pneumonia, in which he made a record of the post-mortem findings. He has examined the clinical data of the cases so far as they are available.

A detailed account of the condition of the different organs as well as the changes in the lungs is given, for which reference must be made to the original paper. The nature of acute lobor pneumonia is discussed, based on the findings of these cases. He classes the cases as primary and secondary. By primary pneumonia he means a disease which begins acutely in the midst of ordinary health and runs the characteristic clinical course. Secondary pneumonia is due to some old-standing primary lesion elsewhere, or to septic absorption or insufflation. The appearance of the lung may be the same in both varieties, and nothing in the morbid anatomy would enable one to distinguish, from the lung lesion alone, whether the disease were primary or secondary. Bacteriologic examination is valueless, as the same organisms are found in both varieties. Only 18 of the 120 cases can be classed as secondary. Of these nine were septic cases, eight were insufflation pneumonia, and one followed opium poisoning. Twenty-one of the cases were associated with Bright's disease, and these possibly may be regarded as secondary, but he includes them in the group of primary cases. While in a general way morbid anatomy does not enable one to distinguish between the primary and secondary pneumonia, to the eye of the trained pathologist the secondary form of the disease does not present that homogenous and uniform appearance which is found in the red or gray hepatization of a primary lobar pneumonia.

Of the 102 cases of primary acute lobar pneumonia, all point conclusively to the fact that this disease is a general febral disease. Its seasonal distribution shows that it is not a local inflammatory infection. The variability of the site of the lesion, occurring in some cases at the base and in others at the apex of the lung, and sometimes simultaneously in the two lungs, points to a general infecti on

Lobar pneumonia is frequently associated with pleurisy of the opposite side and with pericarditis. In three cases pericarditis was found in the right-sided pneumonias, the lesion being situated in the upper lobe. These circumstances point to the general infectious character of the disease. Its association with acute peritonitis indicates a general infection, all the great serous cavities of the body being more or less involved. There is the cloudy swelling of the liver, kidneys and spleen which is usually met with in the specific fevers. One of the strongest clinical arguments in favor of the view that we are dealing with a general infection is found in the constancy with which the crisis of the disease occurs on the seventh or eighth day. By far the largest number of patients died on the seventh day.

Medical Treatment of Acute Attack and Management of Chronic Gall-stone Disease.—Dr. Leonard Weber said that in the treatment of cholelithiasis physicians always could, and can, do a great deal for the relief and cure of their patients, but vastly more can now be done to save life in cases not amenable to medical treatment, since surgeons, following in the path opened to them by Langenbuch, have known how to incise the gall-bladder and clear of gall-stones that viscus as well as the ducts. For an acute attack of biliary colic are required a hypodermic injection of morphine, a hot poultice over the upper abdomen, and a large enema; followed, when nausea and vomiting have ceased, by calomel or compound cathartic pills. For some years he has been in the habit of following up an acute attack for a week or more by enemata of from four to eight ounces of warm olive oil, carried high up into the rectum by a long tube, to be retained over night and followed by copious flushing of the colon with warm water. The patient is then placed upon a proper diet. Gall-stones being composed not only of cholesterin, but also of lime and magnesia, which increase their hardness, all food rich in these substances, and particularly peas, beans and lentils, must be prohibited, and very hearty meals of any kind should be avoided. Alcoholic beverages should be partaken of very sparingly, and the bowels kept extremely regular by sulphate of magnesia, phosphate of soda, or a rhubarb-and-aloes pill. In addition, the patient should take twice a day half a pint of hot Carlsbad Schlossbrunnen or a teaspoonful of Carlsbad Sprudel salts in half pint of hot water. As to massage of the gall-bladder, recommended by some, Dr. Weber said that a glance at the anatomy and situation of the viscus and the ducts ought to suffice to stigmatize any such procedure as injudicious and fraught with mischief. He described five classes of chronic cases which had come under his observation. The first was as follows: Cases of solitary or a few large calculi in the gall-bladder, without enlargement of the latter and without icterus, but accompanied by approaching cachexia and steadily failing health. The diagnosis is very difficult and medical treatment of no avail. In conclusion he said he was by no means of the opinion that, after the surgeon has operated and the patient made a good recovery, everything needful has been done. The gall-bladder, when not excised, is certainly not normal,

nor is the bile the physiological liquid it ought to be. What holds good in the medical treatment for chronic cases without operation will hold good for those which have been operated upon.

Diagnostic Symptoms.—In the first place, jaundice is present in from 50 to 60 per cent. of cases of biliary colic; but so long as the concretion has been caught in the cystic duct no jaundice will result. If there is no jaundice we ought to have the urine tested for biliary pigment, a mere trace of which will throw light on the diagnosis. Secondly, signs in connection with other symptoms of cholelithiasis. There is very little doubt that such signs are due to toxins, and they in every way resemble those in urinary fever, which we now know are caused by the colon bacillus. In the next place it is worthy of consideration that we may have a virulent inflammation of the gall-bladder, sufficient to produce hepatic abscess, and yet find no symptoms of biliary colic. In every case where there is any reason to suspect such a condition the urine should be examined for leucocytosis.

Treatment.—Have we any means, aside from surgical interference, of dealing with gall-stones more satisfactorily than in former days? Dr. Thompson said he thought we had, in the great majority of cases, until the calculus is tightly impacted in the ducts and even after that in a great many instances. To Plimpton, of London, we are indebted for our knowledge of the solution of biliary calculi in oils of various kinds, such as sweet oil, almond oil, and the petroleum oil; which act first on the cholesterin. This, said the speaker, was no longer a matter of hypothesis with him. He was in the habit of relying on olive oil, and he had a special way of giving it. For ten nights in succession the patient takes from one to two ounces in hot milk. Then the oil is omitted for a week, and this course is kept up for a number of months. Oil exerts a special action on mucous membranes in general, and here it has the direct effect of increasing the watery secretion of bile. He said he had from 50 to 80 recorded cases in which this treatment was successful. In addition to the treatment of the gall-stones themselves, we have to deal with the conditions which tend to cause intestinal catarrh, and for this purpose there is nothing so efficient as benzoate of soda. Next in efficacy comes salicylate of soda, and he is in the habit of prescribing ten grains of each of these three times a day after meals. Hoffman's anodyne and chloroform, which have been so long in use in cholelithiasis, also have some solvent action.

The Domain of Medical Treatment Circumscribed.—Dr. Herbert F. Williams said that the domain of medical treatment becomes circumscribed after the development of the true cholelithitic condition, that is, after the formation of calculi. The true and efficient field for medical therapeutics is that in which we seek to combat the various conditions which culminate in such formation. Where calculi, after having become impacted in the common duct, have escaped into the duodenum, the forced dilatation of the duct seems to pre-

pare the individual for subsequent formations which will not create the disturbance of the initial attack. Of course, all measures of treatment are primarily directed to the removal of the concretions, wherever located, and, fortunately, the increasing caliber of the branches of the hepatic duct is a constant equation in preventing permanent arrest in that duct or the longer radicles. Sooner or later concretions find their way into the gall-bladder, where they may either remain undetected and innocuous, or accumulation or concentric enlargement, together with infection through the common duct, may give rise to irritation, ulceration and perforation. When obstruction is not complete we can accomplish something by hepatic elimination, solvents and hepatic massage. Indeed, the most effective hepatic massage is the reflex and frequently violent vomiting concurrent with hepatic colic. As to measures to assist in expulsion of calculi (which expulsion, even if by surgical means, develops the opportunity for subsequent medical treatment), anodynes, whether given by mouth, inhalation, or hypodermically, not only relieve pain, but produce a relaxtion of the walls of the duct; and in this way facilitate the removal of the obstructing mass. The greatest caution, however, is necessary in the administration of anodynes, lest after the attack is over alarming or fatal narcosis may result. Counter-irritation by means of a blister over the seat of obstruction will relieve the recent congestion, thus gaining a little in the lumen of the canal. We can now gently stimulate the biliary secretion, and one of the best agents for this purpose is blue flag (iris versicolor). In conclusion Dr. Williams spoke of the necessity of diet regulation and the exhibition of alkaline waters or their salts, among which sodium phosphate stood pre-eminent.

Hemophilia and Nosebleed Yielding to Thyroid Treatment.—Scheffler (Archives de Médicine et de Pharmacie Militaires, March, 1901) reports a case of a 22-year old soldier, of good family history, who without obvious cause was attacked by purpura and obstinate nasal hemorrhages. This hemophilic condition was absolutely unaffected by ordinary therapeutic agents, and the epistaxis became so persistent and exhausting that permanent blocking of the nasal fossa was necessary. Treatment by thyroid extract exerted an immediate and beneficial effect, and was followed by cure. In three days the violent and persistent epistaxis had practically stopped. In six days, about eight grains of thyroid extract having been given daily, the purpuric eruption ceased and the old spots began to disappear.

GENERAL ORTHOPÆDIAC AND GENITO-URINARY SURGERY.

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REMOVAL OF FOREIGN BODIES FROM THE AIR PASSAGES.—Dr. DeForest Willard (Jour. Am. Med. Assn., Oct. 26, 1901). The entrance of foreign bodies into the trachea is a common occurrence in children, and the old remedy of inverting the patient is a good one, though the body may again be arrested at the larynx and cause suffocation. Rest in an exaggerated prendelenbury position is also advantageous. Coughing should be encouraged and exaggerated inspiratory efforts restrained Succussion and vomiting have occasionally dislodged the body. The body should always be located by the physical signs and not or by the X-ray apparatus, and too much reliance should not be placed upon the history. Neglect of careful diagnosis has lead to the performance of tracheotomy in search of a foreign body which was subsequently passed from the bowel or found about the nursery.

It is still a mooted question whether to open the trachea in case the object is lodged at the bifurcation of the trachea or depend upon the expulsion efforts of nature, but depends largely upon the amount of dyspnœa present. If suffocation is imminent, tracheotomy is indicated. A long slit should be made in the trachea and the sides withdrawn while efforts are made to grasp the object in the jaws of forceps, or sucked up by Biglow's suction apparatus. In about half of the cases expulsion takes place spontaneously soon after opening the trachea, and coughing should be encouraged by tickling the mucous membrane with a feather.

Prolonged instrumentation is apt to lead to fatal pneumonia. Statistics indicate that the results are better if the trachea is opened and the case left to nature rather than persisting in the efforts to dislodge a body from the bronchus.

When the expectant plan of treatment is followed, the object is often coughed up weeks or months after it has been inspired, and with seeds, etc., as high as 74 per cent. are expelled with subsequent recovery.

An examination of the literature has failed to reveal a single instance in which recovery has followed the opening of a bronchus,

though if the necessary equipment be at hand, previous failures should not prevent a skillful surgeon from making the attempt. In all cases an artificial respiration apparatus of one of the standard paters is a requisite throughout the operation.

The bronchus may be reached anteriorly or posteriorly. Milton's method consists of splitting the sternum near the left border at the attachment of the medias tinum, the two layers of which should be separated.

Gaston's method consists of a quadrilatteral flap, including the third, fourth, fifth and sixth ribs, and turned back upon the sternum. It is always necessary to close the wound in the bronchus, otherwise the chest becomes overfilled with air and causes death.

The posterior operation is performed by raising a square flap, including the third, fourth and fifth ribs, and turning it back at the spine. The œsophapus, as well as the bronchus, can be reached by this incision. In this operation the wound in the bronchus should not be closed, packed and the cavity drained. The flapping of the pleura, the rapid dilitation and emptying of the large veins and the extensive excursion of the bronchi during the efforts at inspiration makes the operation one of the greatest difficulty, and it frequently has to be abandoned. G. R. W.

Cholelithiasis and Its Surgical Treatment.—At a meeting of the Medical Association of the Greater City of New York on October 14th, Dr. William H. Thompson spoke of the value of contrasts, as strongly shown in calculus of the gall-bladder and calculus of the urinary bladder. Both present very similar indications for surgical relief, but with this statement all resemblance ceases. Why does it cease? In the first place, biliary calculi may present absolutely no symptoms during life; whereas calculi in the bladder nearly always give rise to symptoms.

It is estimated that at least 10 per cent. of all males over the age of forty have gall-stones which give no signs of their presence during life; while in women of fifty and over the percentage is as high as 25.

In the case of urinary calculus the diagnosis is a very easy matter. We can apply tests to the urine, we can see the stone by means of the cystoscope, and can feel it with the sound. But we have no means of seeing or feeling gall-stones or even of getting a specimen of bile. These contrasts, however, are by no means as great as those regarding the manner in which these respective concretions come into existence.

The Formation of Gall-stones.—Very important progress has of late been made in our knowledge on this point. We know that a gall-stone has nothing to do with a general constitutional state. Hence, in this connection, there is no such thing as a uric-acid diathesis, a phosphatic diathesis, etc. Instead, gall-stones are purely local in origin. They do not come from the liver cells and do not

result from a fault in the secretion of bile. They originate lower down, just as gonorrhea is not a disease of the kidney. This recent knowledge is a great gain and it enables us to dispense with a great many of the supposed remedial measures that were in use twenty-five years ago. For if we are principally indebted to Naunyn, of Strasburg. The bile, as secreted in the liver, is very watery and has very little *vis a tergo*. In amount it is about equal to the urine, from two to three pints a day. When most rapidly secreted, during the active periods of digestion, it passes into the intestines, being propelled by the pressure of the diaphragm and the abdominal muscles and by the intestinal peristalsis. The mouth of the common duct has a sphincter and when active digestion ceases the sphincter is closed. During the night and other intervals of digestion the bile flows back into the reservoir provided for it—the gall-bladder. In the constitution of bile the main inorganic ingredient is lime (calcium). It is normally in solution and it would remain so but for its tendency, under certain conditions, to combine with another ingredient, namely, the red coloring matter of the bile, thus forming a precipitate of calcium and bilirubin. Layer upon layer of cholesterin is deposited and sometimes the formation of gall-stones is very rapid. This cholesterin, to which the bulk is mainly due, forms with great rapidity around a stone already impacted in the duct. As to what causes the original precipitation from the bile of the calcium and bilirubin, and as to what causes the further accretions of cholesterin, this is always due to local catarrh of the mucous membrane of the biliary passages. Cholesterin is a substance widely distributed throughout the body, and especially in the nervous system. Yet it is most commonly produced by the degeneration of epithelial cells, and hence is always found in pus. It is not, therefore, a normal ingredient of the bile, except in very small quantity, and then derived from the epithelium of the gall-bladder. This explains the clinical fact of the great preponderance of cholelithiasis in women. A very important factor in its production is simple stasis or stagnation of bile, and this condition is not difficult to understand when we reflect upon the common inactivity of the muscles of respiration, and add to this relaxation of the abdominal walls, frequently accompanied with ptosis. The most important factor of all remains to be noted. There is not simply a catarrhal condition, but always an infection by micro-organisms, which travel up from the intestines. In at least three-quarters of the cases the particular micro-organism is the bacillus coli; but in some instances we have streptococci, straphylococci, typhoid bacilli, and other germs. Hence, as we see, it is a purely local affair. As to biliary stasis, this is largely due to the habits of the patient, and chronic constipation is one of its chief causes.

OBSTETRICS AND GYNÆCOLOGY.

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THE OPERATIVE TREATMENT OF COLLECTIONS OF PUS IN THE ADNEXA BY VAGINAL INCISION.—Bürger, Gebiertshilflich-gynäkolgische gesellschaft in Wien, May, 1901 (Centralblatt fur gynäkology, Oct. 26th, 1901).—After an analysis of 273 cases in Schanta's clinic B. reaches the conclusion that opening and draining through the vagina a collection of pus in the tube is not a satisfactory procedure owing to the liability of recurrence of the abscess, formation of abscesses in the neighboring cellular tissue or the adnexa of the opposite side, or persistence of fistulæ after removal of the tubes. In half of all cases in which one side only was affected at the time of operation the other side developed an abscess subsequently, and 28 per cent. of all cases thus opened and drained had to submit to a radical abdominal operation at a later date.

The operation, however, has its value in relieving collections of virulent pus when an abdominal operation would be dangerous, but it should be looked upon as a palliative, and a complete cure is to be expected only when the adnexa have been removed by a radical operation.

[These observations do not apply to abscesses in the pelvic cellular tissue, which may be drained very satisfactorily through the vagina.—Ed.] G. R. W.

CORNUAL PREGNANCY; RUPTURE IN THE FOURTH MONTH; OPERATION; RECOVERY.—Dr. Miles F. Porter of Fort Wayne, Ind., read a paper thus entitled at the American Association of Obstetricians and Gynæcologists, September 17, 18 and 19, 1901. He saw the patient sixteen hours after she had been taken with severe abdominal pain accompanied by the usual signs of severe hemorrhage. She had had one living child and one miscarriage, and was near the middle of her third pregnancy. Hasty examination revealed nothing abnormal in the vagina save a slight bloody discharge. Abdominal section was immediately done and a ruptured

cornual gestation sac of about four and a half months with a bicornate uterus found. The belly was filled with blood. The ruptured cornu was amputated and the stump sutured, leaving the ovary and tube attached to the stump. There was profound depression, which was treated by saline rectal injections and the hypodermic administration of digitalin and strychnine. Recovery was uneventful. A large quantity of warm sterile water was left in the abdomen. The intact cornu was much enlarged and attached to the ruptured cornu with a rather long pedicle. The gestation sac was thick save at the point of rupture and composed of uterine tissue. There was no communication between either the sac and the vagina or the tube and the sac. These communications became occluded subsequent to the impregnation. A decidual membrane was present. The presence of this membrane marked the case as one of rupture in an ill-developed cornu of a bicornate of uterus. In tubal and intestinal pregnancy there was no decidual membrane in the sac. An abnormally low implantation of the tube and round ligament accounted for the fact that in this case they were attached to the outer side of the stump left after removal of the sac, and not to the sac itself, as was usual. As a rule, pregnancy in a bicornate uterus terminated normally. In three of the cases referred to in the author's paper, including his own, normal pregnancies had preceded the rupture. He had been able to find reports of but eighteen cases of ruptured cornual gestation sac, which, with his own, made nineteen cases reported to date. The symptoms were those of ectopic pregnancy, save that the rupture occurred later in cornual pregnancy and the hæmorrhage was usually more profuse. A previous history of sterility or of tubal infection pointed to tubal rather than cornual pregnancy.

These two papers were discussed jointly. The discussion was opened by Dr. Edward J. Ill, of Newark, N. J., who endorsed the treatment employed by Dr. Humiston is his case, and said the quicker an operation was done in such cases, and the sooner the abdominal cavity was walled off, the better the chances for recovery of the patient. He agreed with Dr. Humiston as to the quantity of normal salt solution that these patients would receive and absorb. Massage assisted materially in the absorption of the fluid.

Dr. Edwin Walker, of Evansville, Ind., referred to the indications for the use of normal salt solution in the abdominal cavity. He could not see what benefit was derived from the use of normal salt solution in the case of Dr. Humiston, for the reason that there were well organized clots, and these could not have been affected by it. Such clots, when organized, became drier and were absorbed, and the salt solution only aided in the absorption of any septic material that might be present. He believed it was a mistake in all cases to wash out the abdominal cavity with salt solution. By wiping out the cavity with dry gauze it could be made clean, if it was not infected.

Cæsarean Section versus Symphysiotomy.—Dr. Edward Reynolds read a paper at the twenty-sixth annual meeting of the American Gynecological Society in which he discussed the circumstances which render the elective section justifiable in the interests of the child alone.

The following propositions constitute his summary:

1. The Cæsarean section performed late in labor, or in the presence of infection of the uterus or other complicating constitutional conditions, has been shown by the experience of almost every operator who has tried it to have so high a mortality as to be totally unjustifiable when performed in the interest of the child alone.

2. When a Cæsarean section is performed on a healthy woman, early in labor, and under otherwise favorable circumstances, for merely mechanical indications, it has, in skilled hands, no mortality other than the fractional percentage incidental to all considerable operations *per se*.

3. The inconveniencies and high morbidity rate of symphysiotomy render it distinctly inferior to the section as an operation of choice, but it is an operation which, as compared to craniotomy, or prolonged and forcible high forceps work without it, involves almost no increased risk to life. He therefore believes it to be the operation of choice in the somewhat limited number of neglected cases, for which the Cæsarean is ruled out, *i. e.*, those in which the pelvic contraction is within the range where the extraction of a living child without symphysiotomy is difficult or impossible, but after symphysiotomy is safe or easy.

4. The induction of premature labor for contracted pelves results in so high a fœtal mortality as to be unwarranted when placed in opposition to the performance of the Cæsarean section at the beginning of labor and in favorable cases.

In conclusion, he urged his personal belief that no man is justified in performing Cæsarean section as a last resort late in labor, or upon infected or otherwise constitutionally ill women, for the sake of the child alone; but that he who attains the fullest possible knowledge of his cases beforehand may do the section at the beginning of labor on healthy women, with even less risk to both mother and child than is involved in the performance of unusually difficult high-forceps operations through contracted pelves.

Dr. Charles Jewett at the same meeting read a paper on The Place of Symphysiotomy as Contrasted with Section, of which the following are his conclusions:

1. Symphysiotomy is a still useful operation within a very limited range of pelvic contraction.

2. It is suited to conditions in which only a very little additional pelvic space is required for delivery.

3. It is a valuable recourse, therefore, in cases in which forceps unexpectedly prove inadequate.

4. Axis-traction forceps, with the aid of posture, should always be tried before resort to symphysiotomy.

5. Its results would be much improved by restricting it to pelves with a conjugate of not less than 7.5 cm., three inches.

6. Under equally favorable conditions its total mortality should be no greater than that of Cæsarean section.

7. When the pelvic space permits, it should replace Cæsarean section in the presence of exhaustion.

8. Within its proper field, symphysiotomy is better than Cæsarean section for an operator of little experience in abdominal surgery.—*Med. Review of Reviews.*

Fetal or Congenital Rickets.—Henry Ashby, in The Lancet of August 17, 1901, says that many of these cases are not rickets but achondroplasia. In many such cases the superficial likeness to rickets is great. The long bones are stunted and bent and the epiphyses enlarged. Stoeltzner recently examined a fetus affected with what he classed as fetal myxedema. The case resembled rickets, but was certainly not this condition. Pathologic processes probably occur in intra-uterine life, which conduce to deformities and stunting of the bones apart from rickets.

An infant was brought to the Manchester Children's Hospital, having sustained numerous fractures, but with no history of violence; the fractures involved the right humerus and radius, and the left humerus, ulna and femur. There was marked craniotabes. The ribs were abnormally soft and bent inward during inspiration. There was beading of the ribs, but no enlargement of the epiphyses of the long bones or marked curvature. The infant was well nourished and had apparently been born at term. It was fed on cow's milk and water. The fractures were treated and united. When the child was six weeks old the right femur fractured, but this also repaired well. The softness of the occipital bone was so marked that it became very much flattened by the pressure of the head on the pillow. When the infant was nine months of age it had cut two teeth and was bright and intelligent, and was without signs of rickets or deformities of the bones.

In discussing the nature of the case the writer says that it is one that can scarcely be classed as osteomalacia, as this disease goes from bad to worse; it does not occur in infants, and only exceptionally in children. It should not be classed as a case of fragilitas ossium, as in this disease the bones are simply brittle and there is no tendency to bend. Syphilis produces an osteochondritis or epiphysitis, but not so far as he is aware a tendency of the bone to bend as well as to break. The writer attributes the condition to the fact that the mother was 46 years of age and had been more or less debilitated during the pregnancy, as well as suffering from an attack of jaundice. There was, however, no sign of malnutrition in the infant except in the bones.

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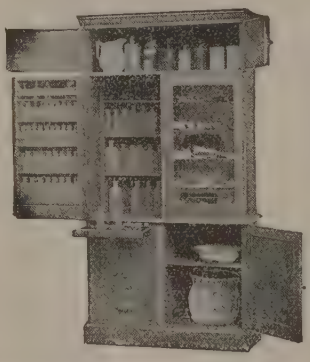

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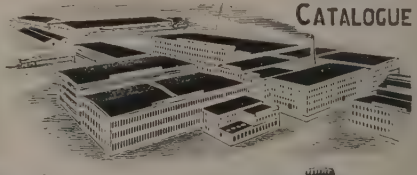

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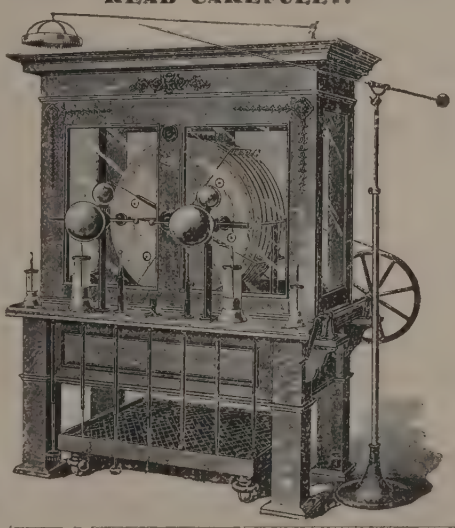

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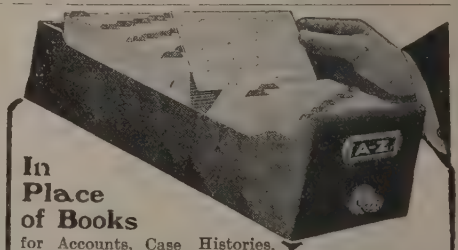

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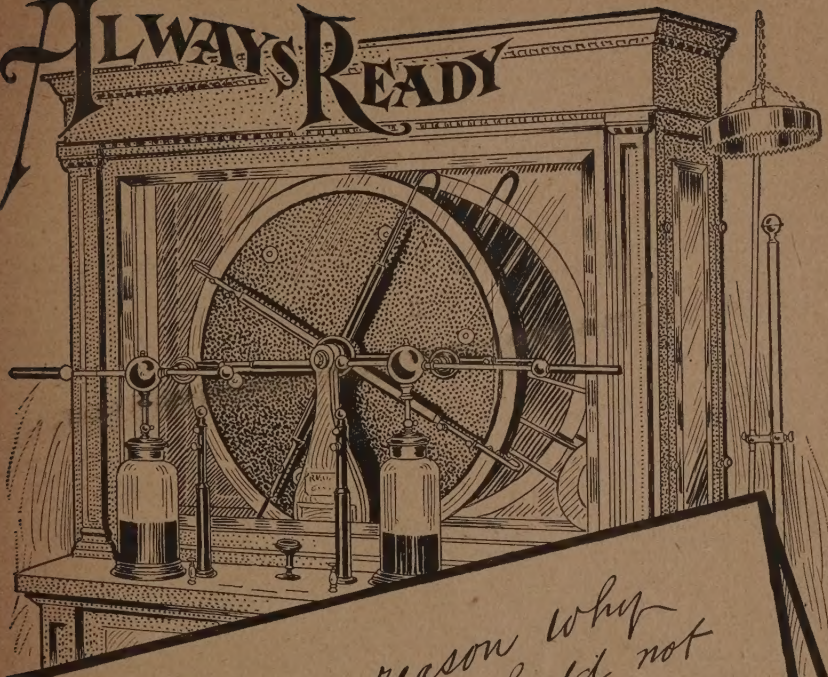

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